# Empathy, Emotional Awareness, and Cognitive Distorting in Child Molesters.

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For Audrey and Ian with love.

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# TABLE OF CONTENTS

APPENDIX N. Extraneous offender responses falling outside main categories.

# List of Tables.

# List of Figures.

# Abstract.

This thesis investigates empathetic ability, level of emotional awareness and level of cognitive distorting, in a sample of 46 male incarcerated child molesters undergoing therapy. Levels of these phenomena are compared to those in child molesters not in therapy, non child molesting criminals, non-criminal controls and contrast groups of students and factory workers. Child molesters undergoing therapy are tested both prior to and following cognitive distortion and victim impact treatment, to ascertain the effects of therapy on these variables.

Child molesters are found to have significantly lower emotional awareness than rapist and non criminal controls ($p<0.0001$), but equivalent levels to those of non sexual offenders such as violent and non-violent criminals.

Distortion levels are significantly higher in child molesting samples than in contrast groups ($p<0.002$), however after therapy, the distortions of child molesters drop to levels equivalent to those of contrast groups. Child molesters tested one year after distortion therapy are found to display significantly higher distortion levels than those tested directly afterwards($p<0.01$).

Three dimensions of general empathy; personal distress, fantasy and empathetic concern, are found to be equivalent in child molesters, students and factory workers. However a fourth dimension, perspective taking, is found to be significantly lower in child molesters than in contrast groups. Some empathy for victims is demonstrated, with child molesters showing relatively accurate predictions of victim impact in comparison to the impact estimates of professional child abuse counsellors (70% agreement in emotion estimates). Molesters show personal distress when faced with abuse scenarios, and their levels of concern for victims increase with victim impact therapy. Some significant changes are noted in offender estimates of victim impact with the manipulation of three variables; age of victim, gender of victim and level of sexual contact.

# CHAPTER ONE

# INTRODUCTION

## 1. OVERVIEW OF THE STUDY.

The research contained in this thesis explores primarily the phenomenon of empathy in sexual offenders against children. The author also examines two additional characteristics, cognitive distortion and emotional awareness, to investigate the relationship between all three attributes and child molesting.

## 1.1. AIM OF THE STUDY.

It is hoped that this work will contribute to knowledge concerning the etiology and treatment of child molesting, specifically with respect to the assessment and treatment of any empathy deficits, emotional awareness deficits and cognitive distortions in this population. This information may be of use to policy makers who thus far have little empirical knowledge to guide them in decisions concerning effective therapy for deficits in these areas.

## 1.2. DEFINITIONS.

All references to child molesters in the current study can be assumed to mean convicted male offenders, unless otherwise stated. This by no means reflects the child molesting population at large which is estimated to contain not only females (Robertson, 1991) but also offenders with less conspicuous psychological abnormality than incarcerated samples. Finkelhor (1984) believes that caught and convicted sex offenders are more compulsive, repetitive, blatant and extreme in their offending and that in all likelihood, they are the offenders with the most deviant developmental experiences. However an understanding of incarcerated individuals can still contribute a great deal to the prevention of recidivism, thereby reducing the harm inflicted on a large number of potential victims (Furby et al., 1989).

In this thesis two terms, - child molesting and sexual offending against children - will be used interchangeably. The term pedophilia will be omitted as not all pedophiles offend and not all child molesters are primarily pedophilic.

## 1.3. RATIONALE IN BRIEF.

According to Finkelhor (1986) the etiology of child sexual abuse requires multifactor explanations of four principal questions; (1) why a person would find relating sexually to a child to be emotionally gratifying and congruent (in the sense of the child fitting the adults needs), (2) why a person would be capable of being sexually aroused by a child, (3) why a person would be frustrated or blocked in their efforts to obtain sexual and emotional gratification from more normatively approved sources, and (4) why a person would not be deterred by the conventional social restraints and inhibitions against having sexual relations with a child.

It is this fourth question which is of particular interest in this study. Marshall and Barbaree (1990) outline several factors which may interact to produce reduced inhibitions against sexual offending. These include poor parenting (particularly harsh and inconsistent discipline along with an absence of love), sociocultural attitudes with a patriarchal emphasis, anger, stress, intoxication, anonymity, and low likelihood of detection and retribution. This study will investigate three other factors; lack of empathetic ability (for victim impact), low levels of emotional awareness, and cognitive distortions of reality. It is proposed that these may also contribute to lower internal inhibition against offending in a person already predisposed towards sexual relations with children.

Only one of these factors, cognitive distorting, has previously been investigated in the child molesting population (Abel et al., 1981, Segal and Stermac, 1990). This literature will be expanded by the following study which aims to explore the extent and nature of these phenomena in a sample of 46 incarcerated child molesters.

## 2. LITERATURE REVIEW.

Surprisingly little empirical work has been done relating empathetic ability, emotional awareness and cognitive distorting to sexual offending against children. Thus, a review of this research alone would be very short indeed. The author has therefore decided to include research that concerns the development and occurrence of these three phenomena in other groups. These groups are drawn from the wider area of antisocial behaviour, however an attempt is made to use those that are most closely matched to child molesting populations.

In the following sections, each of the three phenomena will be defined, research concerning their etiology outlined, and their possible relationship to child molesting and other antisocial behaviours examined.

### 2.1. EMPATHY.

#### 2.1.1. Definition of Empathy.

Despite its common inclusion in the psychological literature, there has traditionally been little consensus concerning a formal definition of empathy. Theorists in the past have tended towards a unidimensional approach, focusing either on emotional aspects (i.e., the vicarious experience of another person's emotional state) (Hoffman, 1984) or cognitive aspects (i.e., the ability to understand another's thoughts and feelings without vicariousness) (Borke, 1971).

More recently it has been recognised that affective and cognitive aspects are both involved as components of a more complex phenomenon (e.g., Deutsch and Madle, 1975 ). Research has begun a trend towards a multidimensional approach (Chlopan et al., 1985), however this latest direction is still in its infancy.

A few researchers have empirically explored more than one dimension of empathy (e.g., Coke et al., 1978), but none so comprehensively as Davis (1983a & 1983b). Davis' theory successfully incorporates the findings of previous studies (Chlopan et al., 1985), proposing that there are four separate dimensions of empathy: perspective taking, empathetic concern, fantasy, and personal distress. Perspective taking refers to a person's ability to adopt the point of view of others (this is considered to be primarily a cognitive characteristic). Empathetic concern refers to feelings of compassion, warmth or concern for another (involving affect rather than cognition). This concept, according to Davis' definition, is interchangeable with that of sympathy; both involve an emotional response arising from the situation of another but not necessarily identical in affect to that of the other. Fantasy is the ability to identify with fictitious characters (involving both cognitive and affective elements), and personal distress refers to the extent to which a person experiences the negative emotions of others (i.e.,' self-orientated feelings of personal anxiety and unease. Fantasy is believed to be a more i.e., orientated component. Davis (1983a) outlines evidence that the four dimensions give predictable and distinct correlations with (a) previous reliable and valid empathy scales (e.g., Mehrabian and Epstein's Questionnaire Measure of Emotional Empathy (1972) and Hogan's Empathy Scale (1969), (b) measures of social functioning, self esteem, emotionality and sensitivity to others, and (c) intercorrelations between the four subscales themselves. Reliability and validity data, and theoretical foundations for the scale are outlined in detail in section 2.1.5.2.

The multidimensional nature of Davis' theory, the validity data and the availability of a practical measuring device based on Davis' findings (the Interpersonal Reactivity Index, appendix A) make this the most comprehensive approach to empathy currently available. Thus, the definition of empathy in this thesis will be that of Davis (1983a) i.e., that empathy is a multidimensional construct with four known dimensions; perspective taking, empathetic concern, fantasy and personal distress.

### 2.1.2. Empathy in Child Molesters.

An understanding of the empathetic ability of sexual offenders by no means explains their offending. However, if empathy is less prevalent amongst sexual offenders against children than in other members of the population, then it may be a possible contributing factor in reducing inhibitions which would normally prevent an adult from acting on their sexual fantasies. Miller and Eisenburg (1988, pg. 324) suggest, based on a number of studies, that "sympathetic and empathetic reactions play an important function in the reduction of...antisocial actions towards others".

Very few studies to date have focused specifically on the empathetic ability of child molesters. In fact, the author is aware of only one investigation by Abel et al. (1985) that reported that 35.8% of a sample of child molesters had empathy deficits compared to 52% of rapists. Unfortunately no details concerning the origin of this figure are specified. Despite this dearth of information there is a commonly held assumption, based on clinical observation, that child molesters are deficient in empathy. This empirically unsubstantiated belief is frequently utilised in the empathy training sections of therapy programmes.

### 2.1.3. Empathy and other antisocial behaviour.

Although research concerning child molesters is rare, there have been a number of investigations relating low empathy to other antisocial behaviour. (It should be noted that antisocial behaviour research is the most related available, however there are still large and important differences between the various types of anti social behaviour outlined and child sexual abuse.)

Hogan (1973) found significant differences in empathy between inmates of a New York reformatory and Air Force officers using his Empathy Scale. Kurtines and Hogan (1972) using the same measure, found significant differences in empathy between non delinquent undergraduates and a group of incarcerated delinquents. In both cases the delinquent youths showed less empathetic ability than their non-delinquent counterparts. Unfortunately, the lack of

matching in both of these studies makes an interpretation of these findings difficult.

Straker and Jacobson (1981) and Wiehe (1987), provide evidence that abusive parents are less empathetic than non-abusive parents, and that abused children are lower in empathy that their non-abused counterparts. Eisenburg and Miller (1987) outline a number of studies correlating prosocial behaviour to empathy (prosocial behaviour being defined as intentional behaviour resulting in benefits for others such as sociability, cooperativeness, helping, and purely altruistic behaviour). Similarly Miller and Eisenburg (1988) conclude in their review that a negative correlation exists between empathy and aggression, externalising, and antisocial behaviours.

However not all studies find a correlation between empathy and anti-social behaviour. Heilbrun, Jr. (1979, 1982) found that violent psychopaths could be divided into two groups; firstly, those who were less intelligent, had less impulse control, less cognitive control and less empathy and secondly, those with a history of offending who were intelligent and highly empathetic. Kaplan and Arbuthnot (1985) found no difference between delinquent and non-delinquent youths on a self reported affective empathy task or a cognitive empathy role taking task. The distinction made by Kaplan and Arbuthnot between the cognitive and affective dimensions of empathy is a very important one, unfortunately ignored by many researchers. This distinction may be crucial in understanding empathetic ability since recent research (e.g., Davis 1983a) indicates that these aspects can show great variation within an individual.

Salter (1984) hypothesises that child molesters may have normal levels of the cognitive empathetic ability needed to take a child's perspective, but a deficit in the affective empathetic ability needed to feel concern for the child.

More research dividing empathy into specific dimensions is needed in order to accurately assess the detailed nature of this complicated phenomenon, especially in the area of sexual offending against children. It is also important that researchers bear in mind

that the dimensions of empathy may not be set traits but instead characteristics, which vary in the individual from situation to situation.

This thesis is essentially a preliminary study investigating the extent of the four dimensions of empathy in child molesters. This will aid understanding of the contribution of empathetic ability to the capacity of child molesters to overcome societal taboos relating to sexual relationships with children. As already mentioned, a deficit in empathy alone is unlikely to cause inhibition. It is more likely that empathy is one of many contributing factors.

### 2.1.4. The Development of Empathy.

If empathetic ability is lower in child molesters than in the non-offending male population (unsubstantiated as yet), then the inclusion of empathy training in rehabilitation programmes for child molesters makes sense, as long as empathy is a phenomenon that can be adjusted (i.e.,' is not permanently fixed at some stage of development). Evidence from two studies suggests that empathy is not a fixed trait. Chandler et al.(1974) and i.e., (1980) have discovered that empathy is not only able to be learned, but that it can be learned in a relatively short time.

An understanding of how this ability is acquired developmentally may provide helpful insights for therapists attempting to achieve the same results via empathy training programmes. It is possible that the success of empathy training may depend on the level of emotional awareness and empathy already present in a subject. If this is the case then training may need to be moulded specifically to the development level of the individual in question. The development of this phenomenon may also be of interest to those attempting to explain the etiology of empathy deficits in child molesters.

The following paragraphs outline briefly Hoffman's (1984) theory concerning the developmental stages of empathetic qualities.

### 2.1.4.1. The development of affective empathy.

Hoffman suggests that certain affective empathetic abilities are present in new born infants, who will cry upon hearing another infant cry. This is due to their inability to distinguish others from themselves. Later, following perceptual discrimination of others, Hoffman believes a type of classical conditioning occurs, where a young child will observe the cues that result in emotions in others and begin to experience the same reaction themselves (for instance a mother's anxiety in certain situations producing the same emotion in her child). According to Hoffman,"direct association" also develops, where the cues of others (e.g., crying, the appearance of blood) remind a child of their own past experiences, evoking emotions. As a child develops, "language mediated associations" arise, stemming from direct associations with past experiences. Language mediated empathy occurs when a victim's distress cues, passed on verbally rather than directly, still evoke emotion in the receiver. Another type of empathy, perspective taking, develops only with more advanced cognitive processes, however this more cognitively based empathetic ability can still cause an affective reaction in the perceiver.

### 2.1.4.2 The development of cognitive empathy.

Hoffman proposes that cognitive empathetic abilities such as perspective taking develop at approximately two years of age. At this stage children begin to recognise their boundaries, and develop an understanding of perspectives other than their own. This cognitive empathetic awareness increases in complexity through childhood alongside other developing cognitive abilities.

### 2.1.4.3. Factors influencing development.

From Hoffman's work then, it seems that all children have the capacity for empathetic development. However, it is obvious from the literature that great variation in the development of this

capacity exists amongst populations (e.g., Straker and Jacobson, 1981).

Parental Influences.

Variability in the capacity to empathise is commonly believed to be linked to the quality of the parent-child relationship (Straker and Jacobson, 1981).

Role modelling of empathy: Research suggests that children develop a capacity for empathy within the context of a caring nurturent relationship. The role model in this relationship sets an example by showing empathetic sensitivity to the child and others in distress (Straker and Jacobson, 1981). In contrast, research suggests that role models who are less empathetic, such as parents of abused children, engage in more negative and coercive interactions with their children, use more punitive rearing techniques, express more negative emotions than non-abusive parents and are less vicariously aroused by their children's pain cues and negative reactions (Kropp and Haynes 1987). The resulting abused children have been found to be less empathetic than non-abused children.

Abusive parenting: Straker and Jacobson suggest that in addition to the lack of parental modelling of empathy, abusive parent-child relationships may also reduce a child's tendency to develop positive feelings towards others and feelings of interconnectedness and identification; factors that are commonly agreed to be important aspects of empathy (Straker and Jacobson, 1981). Based on these findings it is interesting to observe that in at least one study, up to 70% of convicted child molesters had been sexually abused themselves as children (Robertson, 1991). In addition to sexual abuse, Gebhard et al. (1965) in a highly comprehensive exploration of the area, claim that most child molesters come from broken homes and disturbed backgrounds and have experienced social and sexual difficulties all their lives.

It is important to note however that studies of child molesters (e.g., Gebhard, 1965) are usually based only on those who have been caught and convicted. As Finkelhor (1984) points out, this group is small and unrepresentative of all offenders at large.

He believes that this group contains more conspicuous levels of psychological abnormality and more deviant developmental experiences. It is therefore possible that parental influences are not as harsh in those who have not been detected.

Given the above information,it is quite possible that empathy deficits may be one of the outcomes of poor parenting which make parenting a contributing factor to the likelihood of sexual offending (Marshall and Barbaree, 1990). Further research is necessary in order to clarify the extent of empathetic ability in child molesters, the stages involved in its development, and the conditions necessary for enhancing this phenomenon.

### 2.1.5. The Measurement of Empathy.

Of all the research methods developed thus far to measure empathy, questionnaires are believed to be the most effective (Miller and Eisenburg, 1988). However, in the past, questionnaires, like other empathy research, tended to be limited to the measurement of either cognitive or affective empathy. Even the most popular empathy scales (according to Chlopan et al., 1985), the Hogan Empathy Scale (Hogan, 1969) and the Questionnaire Measure of Emotional Empathy (QMEE) (Mehrabian and Epstein, 1972) only measured a single empathy dimension. The Hogan Scale measured cognitive aspects, and the QMEE measured affective aspects. Miller and Eisenburg (1988) suggest that the levels of empathy resulting varied considerably depending on which measure was used. Chlopan et al. conclude their review of available measures by suggesting that a more multidimensional test is needed.

#### 2.1.5.1. The Interpersonal Reactivity Index.

Davis' multidimensional IRI scale was developed in response to this need. The subscales although appearing relatively disparate at first, all have clear links to earlier investigations of empathy (defined broadly by Davis, 1983a, as a reaction to the observed experiences of another). The more cognitive subscale, perspective taking (PT), had separately been the subject of much research,

especially using the Hogan Empathy Scale as a measuring device. Similarly, empathetic concern (EC), had been the object of much study, in particular using Mehrabian and Epstein's QMEE. (For a review of PT and EC research see Chlopan et al., 1985). One group of researchers, Coke et al. (1978), had even studied three dimensions concurrently, (PT, EC and PD) demonstrating them all to be potentially important aspects of empathy. In the IRI however, Davis added a fourth aspect, fantasy, as it had been shown a few years previously that a tendency to fantasise about fictitious situations also influenced a persons emotional reactions towards others (Stotland et al., 1978). Davis does not claim to have covered all possible reactions to others in his scale, however he does believe that it includes what have been shown by previous research to be several important aspects of empathy. Thus far, it is the most comprehensive measure of empathy yet published, in a field where the necessity for a multidimensional approach has been widely recognised. (Deutsch and Madle, 1975, Chlopan et al., 1985).

Davis only briefly refers to a theoretical basis for his scale. He draws his ideas from Hoffman (1977), who proposes that a child's capacity for non egocentric thought (Davis' "perspective taking") mediates the gradual shift from a self-oriented emotional reaction to another's distress (Davis' "personal distress") to a more other-oriented reaction of sympathy and concern (Davis' empathetic concern). One point that Davis does not elaborate on is the difference between other oriented reactions based solely one's own experiences (which may be quite inaccurate for another person's situation), and other oriented reactions drawn also from the evidence available from the other.

Another problem with Davis' theory is that he treats the phenomenon of empathy as a stable trait, not recognising that the various aspects of this ability no doubt vary in an individual from situation to situation.

### 2.1.5.2. Psychometric properties of the IRI.

Although there are one or two theoretical problems in Davis' concept of empathy, his IRI scale is the most comprehensive valid and reliable multi-dimensional scale currently available.

Reliability.

The factor structure of the scale has been found to be stable over repeated administration to different samples, and internal and test-retest reliabilities are also satisfactory (Davis 1983a&b).

Validity.

Discriminant validity has been illustrated by expected correlations between each of the subscales and measures of empathy, self esteem, social competence, emotionality, and sensitivity to others (Davis, 1983b). To be specific, the subscales all correlate in varying degrees with Hogan's Empathy Scale (HES) and Mehrabian and Epstein's Questionnaire Measure of Emotional Empathy (QMEE) (Chlopan et al., 1985). As Davis predicted, perspective taking was most highly correlated with the cognitively orientated HES and was least related to the emotion orientated QMEE (Davis et al., 1987). A study of 1324 students (Davis, 1983a), investigating discriminant validity, found that perspective taking, in keeping with the prediction that it is a fundamental social skill, was consistently moderately related to level of social functioning (mean r=0.15 for eight different measures). It was also related to self esteem (r=0.23) and sensitivity focused on others (r=0.35), and unrelated to levels of emotionality (r=0.02). Empathetic concern was significantly positively related to measures of emotionality (r=0.21) and selfless concern for others (r=0.57), but unrelated to intelligence or self esteem. Personal distress was significantly positively related to social dysfunction (mean r=0.2 for eight different measures), low self esteem (r=-0.40), emotional vulnerability (r=-0.47), self-orientated sensitivity (r=0.21), and unrelated to other-orientated sensitivity. Fantasy was related to emotionality (mean r=19), both self and other-orientated sensitivity (mean r=0.20), and unrelated to either self esteem or social functioning. Intercorrelations between the subscales are also as Davis expected, with all except fantasy and personal distress correlating significantly together. A negative correlation was found between perspective taking and personal distress. Almost all of the above results are predicted and explained in Davis (1983a).

Because of these psychometric properties and the fact that it is the most comprehensive multidimensional scale available, the author believes that it is the most appropriate choice for the following research. However this does not mean that the IRI is faultless. Davis treats the phenomenon of empathy as a stable trait, not recognising that the various aspects of this ability no doubt vary in an individual from situation to situation.
In addition, Davis does not differentiate between the ability to perspective take and feel concern based solely on ones own experiences (which may be quite inaccurate for another person's situation), and the ability to empathise based on cues from the other person.

### 2.1.6. Empathy and Morality.

The link between empathy and morality has been established in a number of studies (Kaplan and Arbuthnot, 1985). This relationship is significant in the light of deficient child molester inhibitions with respect to sexual relationships with children.

Selman (1971) has demonstrated that a cognitive aspect of empathy - perspective taking - is necessary (but not sufficient) for the advancement in level of moral reasoning. According to Selman's finding then, it can be assumed that individuals with low role taking ability will not develop a strong sense of morality. Several studies support this hypothesis by demonstrating that delinquent teenagers show less perspective taking ability than non-delinquent teenagers (e.g., Kaplan and Arbuthnot, 1985), however there is not enough evidence to determine a causal link. One study (Rotenburg, 1974) shows only a non-significant difference in cognitive role taking ability between delinquent and non-delinquent youths. Rotenburg instead shows a significant difference in affective role taking (vicarious experiencing rather than purely cognitive understanding), with non delinquent youths showing greater affective reactions. Similarly Kaplan and Arbuthnot (1985) found no difference between non-delinquent and delinquent youths on cognitive role taking.

Miller and Eisenburg (1988) in a review of empathy and antisocial behaviour, support the hypothesis that the affective processes of empathy are positively associated with moral development. Choplan et al. (1985) also support this hypothesis finding a consistent relationship between people supposedly lacking in morality and scores on the Hogan Empathy scale (a measure of affective empathy).

It seems likely then that empathy and moral development are linked, even though the exact relationship between affective components, cognitive components and morality is unclear.

While some antisocial groups, as reported, have lower empathetic skills, the link between antisocial behaviour, empathy and morality is not necessarily concrete. The findings outlined are also not necessarily related to child molesting. The general public consensus would be that sexual relationships with children are immoral. (This is debatably a cultural issue.) It is somewhat surprising then to find some researchers expressing the opinion that child molesters often come across as highly moralistic (e.g., Gebhard et al., 1965). At first glance this appears contradictory, however, the link may not be as incompatible as it initially appears. It could be argued that there is a difference between being moralistic or rigid in ones thinking (which can often represent a direct ingestion and abidance by prevailing wisdom without thought, i.e.,' level two of Kohlberg's stages of moral development) and a more flexible approach where moral principals are applied sensitively to varying situations with a great deal of thought. It is possible that child molesters who offend are moralistic in the first sense, but that the restraints they put on their behaviour have an effect similar to those described by Ruderman (eg1979) in the eating disorder literature. That is, that the person is highly motivated to restrain themselves, thus depriving themselves to the extreme, but that the resulting negative affect reduces restraint causing a massive pendulum effect (i.e.,' sexual contact with children). Like most theories concerning child molesters this would not apply to all offenders, but may explain the apparently contradictory moral appearance of some.

To conclude then, it may not be an absence of morality but rather an overriding of moral inhibitions that permits a child molester to offend.

## 2.2. COGNITIVE DISTORTION.

The finding that child molesters can be quite moralistic makes sense when it is recalled that these offenders are prone to distorting their cognitions to reduce the dissonance between their behaviour and their awareness of internal or external acceptability of this act (Abel et al., 1989).

### 2.2.1. Definition.

Cognitive Distortion in the context of sexual offending, refers to personal processes including justifications, perceptions, and judgements which are used by an offender to rationalise his child molestation behaviour.

### 2.2.2. The Cognitive Distortion Literature.

Cognitive distortion has been found to be present in child molesters in at least one empirical study (Abel et al., 1989) which demonstrated that child molesters differ from non molesters in their beliefs concerning the consequences of their molestation on the children involved. Several treatment programmes have also identified the normalising of cognitive distortion as being an important element in treatment (Abel et al., 1985). In fact one study reported that altering distorted thinking was the only way to prevent recidivism in career criminals and chronic sexual offenders (i.e., and Samenow, 1977). These postulations follow the direction of research in other areas such as juvenile delinquency where cognitive distortions have been found to be an important factor in both the etiology and maintenance of delinquency (Gibbs, 1989 - cited in Abel et al., 1989). It is assumed (e.g., Abel et al. 1989) that in the case of child molesters, a reduction in distorting would make it more difficult to justify behaviour, resulting in a

decrease in offending. This position is endorsed in the relapse prevention literature (eg Laws, 1989).

### 2.2.3. The Etiology of Cognitive Distorting in Child Molesters.

Abel et al. (1985) hypothesise that a child molester's awareness of the discrepancies between his behaviour with children and acceptable social standards causes him to reduce dissonance by developing cognitive justifications and rationalisations for his behaviour. By distorting his thinking he can avoid awareness of the negative consequences to his victim that may be apparent to a non-distorting adult. This distorting continues to provide protection from condemnation (internal or external) as long as the offender remains undetected and unchallenged. This theory is backed by the observation (Abel et al., 1989) that distorting increases with the number of years an offender continues to molest. They endorse the general consensus that these distortions are learned as a molester attempts to modify his beliefs to justify and rationalise his behaviour.

Abel et al. (1989) suggest that the main conflict arising is not between external social and external reinforcement (i.e.,' the advantages of molestation) but between internal self-condemnation and external reinforcement. This point is important to research in empathy. If child molesters know (beneath their distorting) that what they are doing is wrong, then continuation of abuse may be due to cognitive distorting of that knowledge rather than to a lack of ability to empathise with their victim. If this is the case, then empathy deficits will be found to be offence specific. This thesis will investigate whether this is so or whether general empathy deficits are also apparent.

Also significant is the question of whether distortions occur before an offence, to reduce inhibitions (and override morals), or whether they occur mainly afterwards, as a reaction to awareness of external social norms (implying that knowledge of wrongdoing develops only after an offence takes place).

Thus it is of interest to explore the following; (a) the extent and nature of cognitive distorting exhibited by sex offenders and (b) the relationship of cognitive distortion to emotional awareness and empathetic ability.

### 2.2.4. The Measurement of Cognitive Distortion in Child Molesters.

As with emotional awareness there are very few devices for measuring cognitive distortion. In fact the only published measure currently available, is the Abel and Becker Cognitions Scale.

### 2.2.5. Description of the Abel and Becker Cognitions Scale.

This scale measures cognitive distortions regarding the sexual molestation of children. It consists of 29 items chosen from statements offenders have actually made in treatment, and relies on the fact that offenders will admit to distortions because they have convinced themselves that these are true in their need to i.e., the harmful nature of their actions. Salter (1984), regards the scale as "surprisingly good" because she believes that offenders who hold cognitive distortions are unaware that they are distortions. She proposes that they have persuaded themselves and will often try to persuade others of their beliefs, which means that they freely admit to the distortions. This point will be challenged in the discussion.

#### 2.2.5.1. Psychometric properties of the Abel and Becker Cognitions Scale.

This scale is judged by Abel et al. (1989) to have acceptable inter-item consistency, test-retest reliability, and internal consistency (for the six subscales identified). Validity has been tested successfully using known group comparisons, calculation of severity indices and split halves (see Abel et al., 1989 for details). However, despite these adequate psychometric properties, a number of significant problems concerning the structure and content of the ABCDQ were observed during the administration of this scale . These were a) no question reversal, making the scale

somewhat transparent b) some ambiguity as to the meaning of certain questions and c) the use of "I" instead of the third person or an impersonal pronoun (this more personal reference has been found to increase the level of denial in child molesters, thereby reducing the truthfulness of responses - Morgan, 1991).

However as mentioned, the Abel and Becker Cognitions Scale was the only published scale that specifically measured the cognitive distortions of child molesters. Therefore despite its limitations it was the best psychometrically tested scale available for the purposes of this study.

## 2.3. EMOTIONAL AWARENESS.

### 2.3.1. Definition.

Emotional awareness is defined as the ability to identify specific and differentiable emotions both in oneself and in others. This ability is of interest because of its possible connections to the ability to empathise.

### 2.3.2. Overview.

It seems reasonable to assume that low ability to recognise one's own emotions would correlate with low ability to empathise with others (Lane and Schwartz, 1987). However, this assumption has not, to the authors knowledge, been tested until now. This may be due in part to the fact that only one psychometric instrument (the Levels of Emotional Awareness Scale) has been developed thus far that can test this hypothesis. Furthermore, the measure in question is very recent, and no information is yet available concerning the reliability and validity of the scale or normative data for various sample populations.

As mentioned , Lane and Schwartz believe that there is a strong association between emotional awareness and empathy, and that both are linked closely to cognitive development. In order to understand these relationships it is necessary to outline briefly Lane and Schwartz's developmental hypothesis.

### 2.3.3. Lane and Schwartz's Theory of the Development of Emotional Awareness.

Lane and Schwartz hypothesis draws heavily on two previous developmental concepts; those of Piaget, and Werner and Kaplan (both cited in Lane and Schwartz, 1987). Werner and Kaplan believe that symbolic processes (such as language) represent the nature of internal experiences, and contribute to the development of schemata for those experiences. They believe that describing an emotion not only increases knowledge of it but also aids the development of cognitive structures for it.

Piaget's theory outlines four stages of cognitive development; the sensorimotor, preoperational, concrete operational and formal operational periods. Piaget believes that a child develops cognitively through processes of assimilation (revising what is taken in to the schema) and accommodation (adjustment of the schema to what is taken in). These structural changes cause the child's cognitive schemata to become more coordinated and complex.

Drawing on both of these ideas, Lane and Schwartz propose that emotional awareness develops in parallel with cognitive development. In early infancy the capacity for assimilation is limited. At this stage caregivers are very influential in providing information that modifies both emotional experiences and the schema for those experiences. Gradually the schema that assimilate emotional arousal develop, becoming more differentiated and integrated and able to process more emotional information. Individuals develop new ways of representing experiences which capture more of the information contained in the arousal. For an example of this differentiation, Lane and Schwartz describe how eskimo children are able to distinguish 30 different types of snow, whereas those in Australia are usually limited to one general category. They draw a parallel between snow and emotions, saying that limited schemata mean that differentiable awareness of emotional arousal is also limited. Thus, knowledge about internal emotions, like knowledge about

snow, is determined both environmentally (e.g., by caregivers influencing schemata) and developmentally (i.e.,' the degree of structural organisation present in the cognitive schemata of an individual). Over time, individuals develop more internal control, meaning gradually less reliance on caretakers. One example of this control is the regulation of emotional expression, where an individual becomes able to determine what emotions they share with others.

Therefore, according to Lane and Schwartz, emotional awareness is the result of a chain of processes, many of which are cognitive. Emotional arousal is determined by the cognitive appraisal of an external situation. This arousal itself is then again processed cognitively. The extent of arousal processing is dependent on the cognitive development of the individual, and the schemata available with which to identify particular categories of events.

### 2.3.4. Emotional Awareness and Empathy.

Lane and Schwartz propose that empathy for others must be preceded by cognitive and emotional self awareness. In their own words, "the capacity to empathise with the emotional experience of others is based on the capacity first to imagine oneself in the other's situation and then to experience the emotional reaction one would have if one were in the position of the other" (Lane and Schwartz, 1987, pg. 136). If this is correct then it can be assumed that an individual would need firstly perspective taking ability, and secondly emotional awareness of the self, before being able to be either personally distressed by another's experiences, or concerned for another person. (Labelled PT for perspective taking, PD for personal distress and EC for empathetic concern on the Interpersonal Reactivity Index). Therefore a correlation of these scores should show a positive relationship between level of emotional awareness and PT, PD, and EC. This will be investigated in the current study.

In different research altogether, Davis (1983a) found that fantasy scores on the IRI were significantly correlated to sensitivity and level of emotional vulnerability. From this it can be

predicted that fantasy scores will also show a positive correlation with LEAS scores. This too will be investigated.

Although they believe that emotional awareness is linked to cognitive development, they state that it is not related to intelligence. However, they do point to a relationship between the complexity of emotional representations and the complexity of descriptions of other object representations.

### 2.3.5. The LEAS.

The Levels of Emotional Awareness Scale was designed to enable the empirical measurement of this phenomenon. It is based on Lane and Schwartz's belief that the organisation of the internal world (described above) is reflected in the structure of verbal descriptions of emotion. Verbal reports can be categorised into five hierarchical levels of organisation characterising the various levels of internal development. These levels are:

1. (Sensorimotor-reflexive) This involves no conscious experience of emotions other than perhaps an awareness of the bodily sensations which arise automatically with neuroendocrine arousal.

2. (Sensorimotor-enactive) Emotion is experienced only as a bodily sensation or an action tendency. There is minimal awareness of others as having separate emotional states.

3. (Preoperational) Emotional states are consciously recognised but only one at a time. Structural development means that they are perceived cognitively instead of just at a bodily level. Experience of others' emotions is unidimensional.

4. (Concrete operational) The individual is aware of, and describes complex, differentiated and sometimes opposing emotions. The understanding of the emotions of others is still unidimensional.

5. (Formal operational) The individual is aware not only of their own complex blends of emotions but also has the capacity to empathise with the many feelings of others.

The higher a persons score, the more advanced their emotional awareness is believed to be.

As mentioned, the LEAS thus far has no reliability, validity or normative data. However, despite these short comings, it is based on sound theoretical foundations (Lane and Schwartz, 1987 - see Chp. 1, section 2.3.3.). It provides an opportunity to investigate a phenomenon that until now has been only been measured using physiological arousal or behavioural expression. These objective measurements are inadequate for the measurement of such a subjective internal experience. Although the physiological arousal of two people may be similar, their interpretations of their arousal, and subsequent emotions may be entirely different. behavioural interpretations are also limited, as they depend on second hand estimation rather than direct self reporting (Lane and Schwartz, 1987).

## 3. METHODOLOGICAL PROBLEMS.

Outlined below are a number of problems inherent in the study of child molesters.

### 3.1. OFFENDER TENDENCIES TO DISTORT IN SELF SERVING FASHION.

Sex offenders are renowned for distorting the truth. In fact Abel et al. (1985) found only a 30% concordance of sexual offender self reports of arousal with physiological measurement results, despite detailed consent procedures and highly experienced therapists. Not only are there strong societal pressures against admitting to sexually deviant patterns of arousal, but in a therapy situation, there are many potentially negative consequences for divulging true thoughts and feelings. For example, sexual offenders are aware that what they say to a psychologist will directly affect their likelihood of parole. These strong demand characteristics mean that all self reports concerning such sensitive topics as offender feelings and their predictions of their victims feelings, are undoubtedly biased. However, despite their drawbacks, self

report measures are the only currently available means of accessing such information. It is therefore important that steps are taken to maximise the advantages and minimise the disadvantages of honesty. Those undertaken in this study are outlined in the methodology section.

Evaluation of social desirability factors and likely hood of bias for each individual questionnaire is reviewed in the discussion, Chapter 4.

## 3.2. REPRESENTATIVENESS OF SAMPLE.

Any sample of incarcerated child molesters is unlikely to be representative of the population at large. Not only are there more female offenders at large than are detected (Robertson, 1991 found at least 59% of sexually abused molesters were abused at some stage in their childhood by women- 11% of these exclusively by women), but also there are more offenders with less conspicuous psychological abnormality than incarcerated samples. As mentioned, Finkelhor (1984) believes that caught and convicted sex offenders are more compulsive, repetitive, blatant and extreme in their offending and that in all likelihood, they are the offenders with the most deviant developmental experiences. However, although research on incarcerated child molesters cannot be generalised to those at large, it can still contribute a great deal to the prevention of recidivism, thereby reducing the harm inflicted on a large number of potential victims (Furby et al., 1989).

## 4. AIMS OF THE CURRENT STUDY

Lack of empathy, low emotional awareness, and cognitive distorting, all have the potential to reduce a child molesters inhibitions against sexually abusing children. However, whether these factors do actually influence inhibition, has thus far received very little attention. This thesis aims firstly to examine whether these phenomena exist in unusual levels amongst sexual offenders against children, and secondly to assess the nature of each characteristic in a sample of 46 incarcerated child molesters.

## 4.1. EMPATHY.

The choice of empathy as a focus of this study is based on two main factors. Firstly, very little is known about this phenomenon in child molesters. Deficits are believed to exist, but to what extent and in what areas of empathy, is unknown. Secondly, there is now a device available which can measure the multidimensional aspects of empathy giving very specific information about where potential deficits lie. However, the device employed measures general empathy only. In child molesters a most crucial factor is their ability to empathise specifically with their victims. As outlined in the cognitive distortion section, it is possible that offenders have normal levels of general empathy but are capable of overriding this in specific cases (such as their own victims). Because of the importance of investigating both areas of empathetic ability, a second device was developed by the author to assess empathy towards victims. More specifically, this second scale investigated offender predictions of how child sexual abuse victims would feel in various abuse situations ( to assess the accuracy of perspective taking) and also gauged the feelings of molesters when imagining themselves as the perpetrator in each scene (to assess levels of empathetic concern and personal distress).

### 4.1.1. Assessment of General Empathy.

The IRI was used to measure four dimensions of empathy : perspective taking (PT), empathetic concern (EC), fantasy (F), and personal distress (PD).

#### 4.1.1.1. Aims of the General Empathy Section.

In this study the aim was to:

- investigate the extent of the empathetic ability of child molesters
- compare child molesters' scores to contrasting groups of normative data; i.e.,' factory workers (N=138,

Salter 1984) and male students (N=500, Davis 1983a)

- contrast child molester empathy scores before therapy with those following therapy, to see if general empathetic ability changed with training that focused only on empathy for victims (The success of "empathy for victim" training was measured in the victim impact section.)

- compare intercorrelations of IRI subscales to see if child molester trends were the same as those in two normative samples ( of factory workers and students)

#### 4.1.1.2. Hypotheses Concerning General Empathy.

Hypotheses regarding these results were:

- that child molesters would be able to take the perspective of a child intellectually (i.e.,' PT score equivalent to controls), but not feel concern for the child's well being (i.e.,' EC score lower than controls). Similarly, it was proposed that child molesters would score lower than controls on personal distress. Fantasy scores were predicted to be equivalent to or greater than controls.
- that scores for empathy would not change with therapy, given that the IRI measured general empathy rather than empathy for a victim of child sexual abuse, and given that therapy focused specifically on empathy for victims.
- that inter correlations of the IRI subscales would show similar patterns to those in a non child molesting sample (Davis, 1983a).

### 4.1.2. ASSESSMENT OF EMPATHY FOR VICTIMS.

As mentioned, the Victim Impact Questionnaire was devised by the experimenter in order to establish the empathetic ability of molesters when specifically relating to the victims of child sexual

abuse (as opposed to general empathy in the IRI). As well as investigating an offender's ability to understand the feelings of their victims (i.e., level of perspective taking) this questionaire also examined an offender's perception of their own feelings (i.e., levels of empathetic concern and personal distress).

#### 4.1.2.1. Aims of the Victim Empathy Section.

More specifically, the questionnaire investigated:

- what types of feelings were most prevalent in offenders during and after offences took place (e.g., concern for victim, positive emotions, negative emotions, arousal)
- whether offender predictions of victim feelings were similar to those of professional counsellors of sexually abused children.
- whether child molesters distinguished between levels of sexual contact, or victims of different ages or gender when assessing how a victim would feel.

#### 4.1.2.2. Hypotheses Concerning Victim Empathy.

Hypotheses concerning results were as follows:

- offenders would predict that victims had less negative and more positive feelings in comparison to professional estimations.
- offenders would distinguish between gender, age and level of sexual contact when they estimated victim feelings (for example, from offender's comments in therapy, children between the ages of 7 and 11 would be predicted to have more negative emotions than children less than six years ("too young to know what's happening") and children greater than 12 years ("old enough to be sexually active anyway")

In addition to studying general empathetic ability and empathy concerning child victims of sexual abuse, the author

investigated cognitive distortions to evaluate their nature and extent when compared to controls, and also child molester levels of emotional awareness to discover possible connections between this awareness and empathetic ability.

## 4.2. COGNITIVE DISTORTIONS.

Cognitive distortions have been investigated to a certain extent by Abel, Becker and colleagues, who have established their existence amongst child molesters. The current author wishes to replicate these findings, expanding this knowledge with respect to which distortions are more prominent, and how the distortions of child molesters compare to those in male student populations.

### 4.2.1. Aims of the Cognitive Distortion Section.

The Abel and Becker Cognitions scale is normally used for clinical purposes to enable a therapist to focus treatment on each particular offender's distortions, however here it was used to:

- compare the extent of distortion in child molesters prior to cognitive distortion therapy with the extent of distortion afterwards;
- compare offenders in therapy with those not in therapy (i.e., a non-treatment sample of child molesters and the non-molester contrast group);
- contrast scores before therapy with estimated scores prior to capture (to determine the difference between scores at the time of offending to those after a molester has been through the justice system. It was hoped that this would give at least some indication of the extent of distorting in undetected offenders at large.);
- examine the relationship between cognitive distortions and level of emotional awareness;
- investigate which distortions were most common amongst molesters.

### 4.2.2. Hypotheses Concerning Cognitive Distortions.

Hypotheses concerning results were:

- that there would be a reduction in distortions with cognitive therapy
- that the non-treatment control group of child molesters would show more distortion than the voluntary treatment group of child molesters (the assumption being that those who choose not to have therapy are more likely to believe that they are not doing any harm).
- that the non-molester contrast group would have less distortion than both of the molester samples (treatment and non treatment)
- that treatment group estimates of scores prior to capture would show more distortion than the same groups scores just before therapy began (since they then would have been exposed to various types of disapproval, e.g. from family or the justice system).

Investigations of the link between levels of emotional awareness and distortions, and of which distortions were most common were exploratory and no hypotheses were advanced.

## 4.3. LEVELS OF EMOTIONAL AWARENESS.

### 4.3.1. The Aim of the Emotional Awareness Section.

In this preliminary study the aim was to:

- get an estimate of the level of emotional awareness of child molesters.
- investigate the relationships between emotional awareness and empathy, and emotional awareness and cognitive distorting.

### 4.3.2. Hypotheses Concerning Emotional Awareness.

The hypotheses concerning results (based on Lane and Schwartz's theory of emotional development) were:

-that child molesters would show less emotional awareness than non criminal and non-sexual criminal offenders, but equal emotional awareness to other sexual offending samples (Curtis, 1990).

- that there would be a positive correlation between level of emotional awareness and perspective taking, empathetic concern and personal distress (based on Lane and Schwartz theory, Chp. 1, section 2,.3.3.) and also a positive correlation with fantasy (based on Davis' findings, Chp. 1, section 2.3.4.).

# CHAPTER TWO

# METHODOLOGY

## 1. SUBJECTS.

Subjects were accessed from four sources.
The first group consisted of 47 child molesters undergoing either their first or second year of therapy at the Kia Marama Sex Offenders Unit of Rolleston Prison, Canterbury, New Zealand. (See Appendix B for a description of the therapy programme). These offenders ranged in age from 19 to 53, with a mean age of 37.5 years. Intellectual functioning tests (using the Shipley Institute of Living Scale) gave a mean WAIS equivalent score of 99.93 (sd = 14.12). All child molesters had sexually offended against children under the age of sixteen and at least five years younger than the offender. Therapy was conducted by three clinical psychologists and three nurse therapists, each assigned to a group of approximately nine offenders for the duration of therapy.

The second group consisted of 22 child molesters from Paparua Prison, presently not in formal therapy (referred to as the "non-treatment control"). Ages ranged from 21 to 43 with a mean age of 31. Again all had sexually offended against children under the age of 16 and at least five years younger than the offender.

The third group (a contrast group comprising 17 third, fourth and fifth year male university students, referred to as the "non molester contrast group") was obtained from the Psychology Department of the University of Canterbury, Christchurch, New Zealand. Ages ranged from 20 to 28, with a mean age of 23. Although it was impossible to ascertain whether any child molesters existed in this sample, it was reasonable to assume that numbers would be low.

A fourth contrast group was used in the study of victim impact to ascertain the similarity between sex offender estimations of victim impact and those of professional

psychologists working exclusively with the victims of child sexual abuse. It was hoped that this professional group would provide a reflection of the sorts of feelings that victims commonly reported concerning their abuse. The limitations of using such a group were recognised (e.g., bias, non-impartiality), however it was still considered that professionals (who experienced victims emotions first hand) would be the best group and severest contrast by which to gauge the similarity between offender judgements and victim feelings.

A certain level of literacy was required in order to ensure acceptable levels of comprehension and accuracy in written responses. Those who did not meet this criterion were identified by the psychologists working with each subject. It was reasonable to assume that university students automatically reached this level.

**2. CONSENT.**

All subjects involved in this study were given the option to refuse participation, with no negative consequences. The treatment group underwent therapy on a voluntary basis, and all non-treatment groups (including the students) were informed before testing that they were under no obligation to participate. In addition they were given a document reassuring them of the voluntary nature of the study, of anonymity and of protection against any negative repercussions whatsoever resulting from their participation (a copy of this document can be found in Appendix C).

In all cases a brief explanation of the purpose of the research was provided before participation. The description of the aim of the study was in general terms, since knowledge of specifically what each questionnaire sought to measure would have potentially distorted results. This was especially true for the cognitive distortion and empathy questionnaires. Thus, it was necessary to be somewhat vague when describing these instruments. (For example "We're interested here in your thoughts concerning these various comments. We want to know which ones you agree with and which ones you don't", rather than "we want to know the extent of

your cognitive distorting". Similarly, "we're interested in your opinions about what a person in that situation would feel", rather than "we want to know whether you can empathise with this person." Therefore, although subjects were not misled about the aims of research, they were also not made aware of some of the more specific aims of some questionnaires. Because of this it was important that they be debriefed after the data collection phase by informing them of the aims of the research in more detail, and ensuring that none had any residual negative emotional effects either from the content of the assessment instruments they had completed, or from the nonspecific nature of their pre-testing briefing. This procedure met with ethical committee guidelines.

**3. EXPERIMENTERS.**

Testing of the non-treatment control and the non-molester contrast group was performed by a 22 year old female Master of Science student from the University of Canterbury Psychology Department. Testing of the child molesters (at the Kia Marama therapy unit) was administered by the staff member involved with each group. Although this meant tests were given by a variety of people, the tests themselves involved written instructions, questions and responses only and therefore variations in staff administration were of minimal influence.

**4. SETTING.**

The non-treatment controls were tested individually at the prison, answering questionnaires at a desk in an office-like room with the experimenter present to answer any inquiries or problems. Group testing was impossible because of severe space limitations.

The treatment subjects were tested both in their small groups(although no conferring was allowed ) and, if time was limited, in the privacy of their own cells at night. Again, it was requested that there be no communicating whilst questionnaires were answered. Subjects were given as much time as they needed for questionnaire completion.

## 5. METHODOLOGICAL PROBLEMS.

In this study the steps taken to avoid the specific problems encountered when studying child molesters (detailed in the first chapter) were as follows. To minimise the disadvantages of being honest, firstly, all subjects were tested after having pleaded or been found guilty of their offence, and after sentencing had been completed. This diminished legal incentives to deny or distort offending. Secondly, all subjects participated in the therapy program on a voluntary basis, aware that they could quit at any time should they choose to do so. Thirdly the atmosphere in therapy was deliberately made as supportive and non threatening as possible, with special efforts made to encourage sincere and honest discussion.

However, despite these attempts to increase honesty, some highly influential factors were unavoidable. For example, the psychologists running the therapy programmes had influence in the parole opportunities of the offenders in therapy. Also, questionnaires were unable to be completed anonymously in the treatment group because of the use of the resulting information in therapy. (Questionnaires given to other child molesters not in the program and to students were anonymous.) The author observed discrepancies in the reports of offenders during earlier therapy sessions and in questionnaires, however honesty seemed to increase over the duration of testing.

## 6. DEPENDENT VARIABLES.

All information was gathered using four questionnaires:

The Abel and Becker Cognitive Distortions Questionnaire (ABCDQ)
The Interpersonal Reactivity Index (IRI)
The Levels of Emotional Awareness Scale (LEAS)
The Victim Impact Questionnaire (or VIQ)

Copies of these questionnaires can be found in Appendices A and D. Details of the psychometric properties of these scales, and the reasons for the selection of each are outlined in chapter one

(sections 2.1.5, 2.2.5 and 2.3.5). The following sections briefly describe the scales and the scoring procedures for each. Specific details concerning the use of each scale in this study will be outlined later in the design section.

## 6.1 THE ABEL AND BECKER COGNITIONS SCALE.

This scale measures cognitive distortions regarding the sexual molestation of children. It consists of 29 items drawn from statements offenders commonly make in treatment. Scoring of the ABCDQ involves adding all 29 item responses, from 1 ("strongly agree") to 5 ("strongly disagree"). A possible high of 145 indicates that no distortions are present. The lower the mark, the greater the number of distortions.

A description of the psychometric properties and theoretical foundations of this scale can be found in section 2.2.5.1, Chp.1.

## 6.2. THE INTERPERSONAL REACTIVITY INDEX.

This 29 item scale measures four dimensions of empathy: perspective taking(PT), empathetic concern(EC), fantasy(F), and personal distress(PD). This index is scored on a 5 point scale from 0 ("does not describe me very well") to 5 ("describes me very well").Some items are scored in reverse (see Appendix E).

A description of the psychometric properties and theoretical foundations of this scale can be found in section 2.1.5., Chp.1.

## 6.3. LEVELS OF EMOTIONAL AWARENESS SCALE.

### 6.3.1. Description of the LEAS.

This is a 20 item self report questionnaire created by Lane and Schwartz (unpublished) and founded on their cognitive-developmental theory of emotional development (1987). In each of the 20 scenarios a subject must write a) how he would feel in that situation, and b) how the other person would feel. From the response given, a level of emotional sophistication can be

established for each subject (see chapter one, section 2.3.5 for details).

### 6.3.2. Scoring of the LEAS.

Scoring, as outlined by Lane and Schwartz in the glossary accompanying their scale, depends on the level of emotional awareness shown. For example, a purely physical description (e.g., tired) is given a low score, whereas a description containing highly specific and distinct emotions gets a high score (see section 2.3.5., Chp. 1) Scores are out of a possible 100 (for extremely high emotional awareness). Twenty scenarios are described and the subject is asked to rate firstly how he would feel in that situation and secondly how he thinks the other character in the scenario would feel. For each scenario a subject is scored three times. Once for the level of sophistication of his feelings, once for the level of sophistication of feelings he attributes to the other character, and finally an overall score representing the highest level of sophistication shown by the first two scores. The maximum score in each scenario is 5. A final total is calculated from the third score in each scenario, making a possible highest total of 100 for twenty scenarios.

A description of the psychometric properties and theoretical foundations of this scale can be found in section 2.3.5 Chp.1.

## 6.4 THE VICTIM IMPACT QUESTIONNAIRE

This questionnaire was devised by the experimenter in order to establish

a) an offender's perception of the feelings of their victims, and

b) an offender's perception of their own feelings.

### 6.4.1 Description of the questionnaire.

The questionnaire contained 24 scenarios describing various sexual interactions between an adult male and a child. The

scenarios varied on three dimensions; age, gender and level of sexual contact. This was to enable the monitoring of any variations in empathetic response that might occur because of these factors.

Details of the three variables were as follows:

gender 12 male victims, 12 female victims

age less than six years = eight scenarios
seven to eleven years = eight scenarios
between twelve and fifteen years = eight

level of sexual contact
fondling of victim including genitals
oral sex/masturbation (either of victim by offender, or of offender against victim's body)
penetration of victim (with finger or genitals)
genitals)
force (using physical pressure to sexually molest a child against their will)

[*Although physical force is not a well known feature of child sexual abuse, it is still prevalent in may cases. Some studies (e.g., Gebhard et al., 1965) find as little as 12% of child molesters using force, however Christie, Marshall and Lanthier (1978) report this figure to be 58%. Thus the inclusion of a force category was warranted.]

Scenarios were developed after consultation with a clinical psychologist working at the Kia Marama sex offenders unit, to ensure that descriptions of abuse were as realistic as possible. Apart from gender, age and level of sexual contact, details were kept to a minimum to enable offenders to personally relate as closely as possible to each scene described.

Scenarios were ordered in a random fashion and each was followed by two questions:

1. How does (name of victim) feel?

2. How do you feel?

Subjects were asked to respond to the questions as if they were the adult in each case. These questions were deliberately made open ended so as not to restrict the answer given.

In order to establish the similarity between offender estimations of victim feelings, and actual victim feelings, five professional psychologists working with sexually abused children (and therefore experiencing first hand children's descriptions of abuse) completed the first question in each scenario.

### 6.4.2. Scoring.

Scoring of the Victim Impact scale differed depending on which section of the question was being answered (either section 1. "How does ...(the child) feel?", or section 2. "How do you feel?"). Scoring of the first section (prediction of victim feelings), involved transferring every emotional response to a question on to a scoring chart (see Appendix G for a copy of this chart). There was one chart for each subject, and on it were scoring sections for each of the 24 questions. Each individual question section had 29 boxes representing emotion categories. A tick was put in each box that was mentioned by the offender. If more than one example of a particular emotion category was given to a single question, only one mark was recorded.

The scoring on these charts could then be totalled in two ways.
Firstly, question by question, (i.e., adding all subject responses for a certain question together), to assess differences in offender responses with different victim age, gender and level of sexual contact. The emotion responses for each question were tallied in groups (i.e., numbers of positive emotions, numbers of negative emotions etc)

Secondly, subject by subject, to assess differences in offenders estimates from pre- to post-therapy and between offenders and professionals. In this case each of the 29 emotion categories were tallied separately ( with each subject's total for each emotion (in 24 questions) being recorded. Then offender totals

were compared both pre- and post-therapy, and to professional totals .

Categories were devised with the aid of an academic psychologist specialising in emotion. These were deliberately specific and numerous to reduce scoring confusion. (See Appendix H for list of emotion categories.)

A different procedure was used for the second part of each question since different information was required. Responses were divided up into categories after testing. These categories were established directly from the answers received from subjects (i.e., there was no prior categorisation prepared). This was to enable as accurate a representation of these free responses as possible. Again results were recorded by subject and by question onto a spreadsheet (see Appendix I for category definitions and scoring chart). Results were recorded subject by subject to see if changes in offender feelings occurred from pre- to post-therapy. Results were analysed question by question to investigate offender differences in positive and negative feelings with victim age, gender and degree of sexual contact.

## 7. DESIGN.

### 7.1. THE ABEL AND BECKER COGNITIONS SCALE.

The Abel and Becker cognitive distortions questionnaire was administered to three groups (the treatment group of child molesters, the non-treatment group of child molesters and the contrast group of students). An anova was used to test significance between groups and a within group repeated measures t-test was implemented in the case of treatment group subjects tested both prior to, and following cognitive distortion therapy (a time difference of eight weeks). A further within group repeated measures t-test was implemented to test the significance of differences between pre therapy and estimated pre caught scores on the ABCDQ.

## 7.2. THE INTERPERSONAL REACTIVITY INDEX.

The Interpersonal Reactivity Index was administered only to treatment group subjects, as the aim was to investigate the extent of each of the four types of empathy in a child molesting sample, both before and after therapy. As normative data was available (Davis, 1983a), the child molester results were also compared to this. Testing used a repeated measures design (subjects being tested both before and after therapy) and the scores from each dimension of the scale were compared both within the group (pre- and post-therapy), and between groups (i.e., to normative data). Data was also analyzed using correlational techniques to investigate the relationships between the four dimensions of the IRI, and also the relationship between IRI scores (general empathy) and those from the LEAS (emotional awareness) and the ABCDQ (cognitive distortions).

## 7.3. THE LEVELS OF EMOTIONAL AWARENESS QUESTIONNAIRE.

The Levels of Emotional Awareness Scale was administered both to treatment group subjects before therapy, and to treatment group subjects who had one year of therapy. A between group design was used to measure significant differences between these two groups and two control groups of non child molesters (Curtis, 1990). Scores were also correlated with IRI and ABCDQ scores to investigate relationships between cognitive distortion, empathy and emotional awareness.

## 7.4. THE VICTIM IMPACT QUESTIONAIRE.

The Victim Impact Scale used a within subjects design to compare subject perceptions before and after therapy, and a between subjects design to compare subjects responses to those of professional child sexual abuse counsellors. Also implemented were analyses of the variance of predictions with changes in victim age, gender, and level of sexual contact.

## 8. PROCEDURE.

Testing of treatment group subjects occurred firstly as part of the initial assessment phase of the sex offender treatment program ("pre-therapy") and then again 8 weeks later following the cognitive distortion phase of therapy. In pre therapy testing subjects completed all four questionnaires (the LEAS, ABCDQ, IRI and VIQ). After therapy, only the ABCDQ, IRI and VIQ were re-tested. The LEAS was administered also to subjects who had completed one year of therapy. Because therapy sessions lasted about 1 1/2 hours it was not possible to complete all four questionnaires in one session. However, all subjects finished all four questionnaires within two days.

Prior to testing every questionnaire was reviewed to make sure that wording was appropriate for the population (i.e., clear, simple and common across cultures). Before each questionnaire, subjects were requested to ask if they had problems at any stage understanding a question. Some ambiguity was found to be present in many of the questions in the ABCDQ as mentioned. This point will be addressed in detail in the discussion. For the purpose of uniformity, experimenters read out the instructions for completing each test directly from the top of the questionnaire. Then the procedure for answering questions was briefly re-explained. (See instructions at the beginning of each questionnaire in Appendix D)

Non-treatment group testing occurred individually, with each subject being given the same instructions before testing as those given to the treatment group (on the questionnaires themselves). Similarly, students were also given these instructions.

For the cognitive distortions questionnaire and the IRI, knowledge of specifically what the questionnaire sought to measure would have potentially distorted results, so it was necessary to be somewhat vague when describing these instruments. (For example using the words "cognitions" or "thoughts" rather than "cognitive distortions".

As already mentioned, subjects were debriefed after the data collection phase by informing them of the general aims of the research and ensuring that none had any residual negative

emotional effects from any of the content of the assessment instruments they had completed.

# CHAPTER 3

# RESULTS

## 1. ABEL AND BECKER COGNITIONS SCALE.

Groups involved were:-

A. Child molesters in therapy;
   A1 : pre-therapy; subjects tested prior to treatment,
   A2 : post-therapy; the same subjects tested eight weeks later after cognitive distortion therapy. (N=27 pre, 18 post).
B. Child molesters who were in their second year of treatment.
C. Child molesters not in treatment. (N=22, results courtesy of R.Morgan).
D. Male Student Contrast. (N=17).
E. Child molesters before therapy (from group A1) who estimated what their ABCDQ scores would have been before they were caught.

### 1.1. Anova Results.

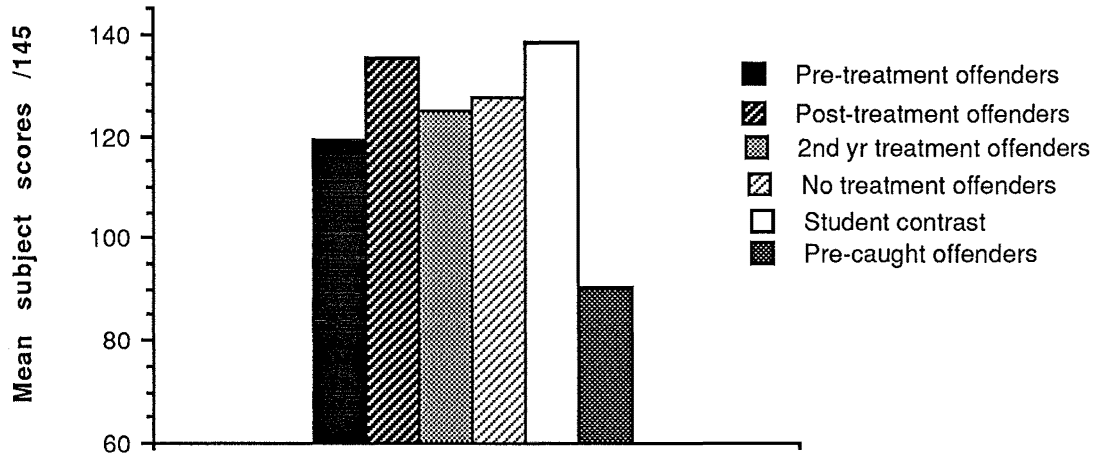
An anova comparing the scores of groups A1, B, C and D, showed that groups A1, B and C had significantly more distorted scores than group D, ($F(3,85)=5.66$, $p<0.002$). An anova comparing group A2 to groups B, C and D, showed that, in addition to the above findings, group A2 had significantly less distortions than group C,($F(3,77)=4.88$, $p<0.005$). See Table 1 for means and standard deviations, and Figure 1 for a graphical presentation of mean scores.

Table 1: ABCDQ Scores

| | N | *Mean /145 | SD |
|---|---|---|---|
| A. 1st Year therapy group | | | |
| A1 - before treatment | 27 | 119.2 | 18.4 |
| A2 - after treatment | 18 | 135.4 | 8.6 |
| B. 2nd year therapy group | 20 | 125.0 | 15.1 |
| C. Non treatment control | 22 | 127.5 | 15.2 |
| D. Student contrast group | 17 | 138.2 | 4.3 |
| E. A1's estimating pre-caught scores | 8 | 90.6 | 21.2 |

* A lower score indicates more distortions

Figure 1. ABCDQ Scores.



### 1.2. Within group t-test comparisons.

A t-test of the total scores obtained by group A subjects both before and after therapy showed a significant reduction in distortions present ($p<0.0001$). A frequency distribution of these pre- and post-therapy ABCDQ scores showed that 33% of subjects scored less than 114 before therapy. No subjects scored in this range following treatment. (See Appendix J for frequency distribution details.)

### 1.3. Pre-therapy vs. pre-caught results.

A t-test comparison of scores just prior to the onset of therapy with those estimated by subjects to be their response before they were caught or brought to the attention of authorities, showed a highly significant decrease in distorted cognitions from time of capture to onset of therapy, ($p<0.0001$). ($M= 119.95, 90.6$, $SD= 18.4, 21.17$, respectively for pre-therapy, pre-caught.

Information concerning the strength of particular distortions in both molesting and non molesting samples can be found in Appendix K.

## 2. LEVELS OF EMOTIONAL AWARENESS.

Child molesters undergoing therapy were divided into two groups to enable a comparison of mean LEAS scores before therapy (group 1) to those after 1 year of therapy (group 2). Both groups were also compared to rapists and non criminal controls (Curtis, 1990). All groups were matched for age, sex, socio-economic status and IQ. See Table 2 for means.

Table 2. Group Means for the LEAS

| Group | Count | Mean Score | Std Dev |
|---|---|---|---|
| Child molesters: | | | |
| Before Therapy | 26 | 47.23 | 13.47 |
| After 1 year | 20 | 45.95 | 13.01 |
| Rapists* | 10 | 58.30 | 8.01 |
| Violent offenders* | 10 | 50.30 | 11.31 |
| Non-violent offenders* | 9 | 47.78 | 5.91 |
| Non-criminal controls * | 10 | 62.70 | 6.20 |

* Scores from Curtis (1990).

Rapists: mean age = 30.3 years, (SD = 8.1), mean full scale IQ = 98.4 (sd=14.9)

Violent offenders: mean age = 25.1 years, (SD = 5.1), mean full scale IQ = 97.3 (SD=16.9).

Non-violent offenders: mean age = 26.0 years, (SD = 3.5), mean full scale IQ = 87.2 (SD= 15.1).

Non-criminal control: mean age = 29.2 years (SD = 5.3), mean full scale IQ = 114.5, (SD = 9.5).

An unpaired two tailed t-test on the child molester means (before and after therapy) showed no significant difference between groups.

Unpaired two tailed t-tests were used to compare these child molester means individually with those found in groups of rapists, violent offenders, non-violent offenders and non-criminal controls (Curtis 1990). Results showed a significant difference between both first and second year child molester groups and the non-criminal control, ($p<0.0001$), and also a significant difference between both groups of child molesters and rapists ($p<0.0001$). There were no significant differences between child molester

samples and the non-violent offenders, or child molesters samples and violent offenders.

The relationship between level of emotional awareness and aspects of empathy was investigated by correlating LEAS scores with each IRI variable, both prior to and following therapy [see Table 3].

Table 3. Correlation between LEAS and IRI subscale scores

| IRI subscale: | Correlation with LEAS: |
|---|---|
| PT(pre) | -0.40* |
| EC(pre) | -0.16 |
| F(pre) | 0.02 |
| PD(pre) | 0.49** |
| PT(post) | -0.32 |
| EC(post) | -0.28 |
| F(post) | 0.20 |
| PD(post) | 0.20 |

* sig. $p<0.05$
** sig. $p<0.01$

LEAS scores were significantly correlated only with perspective taking (pre-therapy, $p<0.05$) and personal distress (pre-therapy, $p<0.01$).

The relationship between cognitive distortion and level of emotional awareness was investigated by correlating LEAS scores with Abel and Becker scores (see Table 4).

Table 4. Correlation Matrix between A&B and LEAS scores

| | Correlation with LEAS: |
|---|---|
| Pre A&B Score | 0.22 |
| Post A&B Score | 0.004 |

There are no significant correlations between these two scale scores.

### 3. THE INTERPERSONAL REACTIVITY INDEX.

As mentioned the IRI measures four different aspects of empathy, perspective taking, empathetic concern, fantasy and personal distress. Average child molester and contrast group scores on these four dimensions are presented in Table 5.

Table 5. IRI Mean Scores

| | P.T. mean SD | E.C. mean SD | F.S. mean SD | P.D. mean SD |
|---|---|---|---|---|
| 1st Years (N=23) | | | | |
| Pre therapy | 15.75 (4.8) | 19.17 (4.5) | 14.52 (5.3) | 11.17 (5.3) |
| Post therapy | 14.35 (4.4) | 17.13 (5.0) | 12.78 (6.5) | 10.83 (5.3) |
| 2nd Years (N=20) | 15.75 (4.8) | 20.50 (4.8) | 12.55 (6.6) | 12.70(5.2) |
| Factory Workers (N=138, male) | 18.40 | 20.20 | 13.43 | 11.10 |
| Student Contrast (N=500, male) | 16.78 | 19.04 | 15.73 | 9.46 |

T-Tests were used to examine the significance of differences between first years, second years, factory worker contrasts and student contrasts, on all four empathy dimensions.

Pre- and post-therapy scores for first year subjects used a two-tailed, paired (within group) t-statistic. Comparisons between first and second years used a two-tailed, unpaired (between group) statistic. Where child molester scores were compared to factory

and student contrasts, the contrasts (N=138 factory workers; N=500 male students) were classed as populations for the purposes of calculating significance (i.e. one group T-test).

### 3.1. Perspective Taking.

Significant differences in perspective taking ability were found between:

a. factory workers and all treatment group subjects (first years pre- and post-therapy and second years), with factory workers showing more perspective taking ability in each case, and
b. the student contrast and first year treatment group subjects (post-therapy), with students showing more perspective taking ability (see Table 6).

Table 6. T-Test results for Perspective Taking.

| | 1st Years Pre | 1st Years Post | 2nd Years |
|---|---|---|---|
| 1st Years Post | N.S | | |
| 2nd Years | N.S. | N.S. | |
| Factory Workers | #Sig. (p<0.01) | #Sig. (p<0.001) | #Sig. (p<0.05) |
| Students | N.S. | +Sig (p<0.05) | N.S. |

\# factory workers greater
\+ students greater

### 3.2. Empathetic Concern.

Significant differences in empathetic concern were found between:

a. first years (post-therapy) and second years, with second years showing more empathetic concern, and

b. first years (post-therapy) and factory workers, with factory workers showing more empathetic concern.

Moderate differences were also found between first years (pre-therapy) and first years (post-therapy) ($p<0.0577$) and between the student contrast and first years (post-therapy) ($p<0.085$). However these were not significant at the 0.05 level (see Table 7).

Table 7. T-Test results for Empathetic Concern:

| | 1st Years Pre | 1st Years Post | 2nd Years |
|---|---|---|---|
| 1st Years Post | N.S. | | |
| 2nd Years | N.S. | ^Sig. ($p<0.05$) | |
| Factory Workers | N.S. | #Sig. ($p<0.01$) | N.S. |
| Students | N.S. | N.S. | N.S |

# factory workers greater
^ 2nd years greater

### 3.3. Fantasy.

Significant differences in fantasy were found between:

a. first years (post-therapy) and student contrasts, with student contrasts showing more ability to identify with fictitious characters (i.e., fantasy), and
b. second years (post-therapy) and student contrasts, with students again showing more ability to identify with fictitious characters (see table 8).

Table 8. T-Test results for Fantasy:

| | 1st Years Pre | 1st Years Post | 2nd Years |
|---|---|---|---|
| 1st Years Post | N.S. | | |
| 2nd Years | N.S. | N.S. | |
| Factory Workers | N.S. | N.S. | N.S. |
| Students | N.S. | +Sig. ($p<0.05$) | +Sig. ($p<0.05$) |

+ students greater

### 3.4. Personal Distress.

Significant differences in personal distress were found between second years and student contrasts only, with student contrasts showing less personal distress about the negative emotions of others (see Table 9).

Table 9. T-Test results for Personal Distress:

| | 1st Years Pre | 1st Years Post | 2nd Years |
|---|---|---|---|
| 1st Years Post | N.S. | | |
| 2nd Years | N.S. | N.S. | |
| Factory Workers | N.S. | N.S. | N.S. |
| Students | N.S. | N.S. | ^Sig ($p<0.05$) |

^ 2nd years greater

### 3.5. Correlations between the subscales.

A correlation matrix, investigating the relationships between IRI subscales to compare child molester trends to norms provided by Davis (1983a), indicated that prior to therapy, personal distress and perspective taking were significantly correlated (r=-0.395). After therapy, perspective taking was significantly correlated with both fantasy (r=0.438) and personal distress (r=-0.456), and empathetic concern was significantly correlated with fantasy (r=0.415) (see tables 10 and 11).

Table 10. Correlation Matrix for Pre IRI Scores:

| | PT (Pre) | EC (Pre) | FS (Pre) | PD (Pre) |
|---|---|---|---|---|
| PT (Pre) | 1 | | | |
| EC (Pre) | 0.265 | 1 | | |
| Fs (Pre) | 0.092 | -0.096 | 1 | |
| PD (Pre) | -0.395* | 0.046 | -0.12 | 1 |

* $p<0.05$

Perspective taking is significantly correlated with personal distress ($p<0.05$) before therapy.

Table 11. Correlation Matrix for Post IRI Scores:

| | PT (Post) | EC (Post) | FS (Post) | PD(Post) |
|---|---|---|---|---|
| PT (Post) | 1 | | | |
| EC (Post) | 0.37 | 1 | | |
| Fs (Post) | 0.438* | 0.415* | 1 | |
| PD (Post) | -0.456* | -0.099 | 0.044 | 1 |

* $p<0.05$

Perspective taking is significantly correlated with fantasy and personal distress ($p<0.05$), and empathetic concern is significantly correlated with fantasy ($p<0.05$), after cognitive distortion therapy.

## 4. VICTIM IMPACT.

Results from the victim impact questionnaire were divided into two sections. The first section investigated the accuracy of perspective taking when related specifically to child victims of sexual abuse. The second section gauged the personal distress and empathetic concern felt by offenders in response to abuse scenarios.

The groups involved in this section were:

Child molesters before therapy (N=26)
Child molesters after therapy (N=20)
Professional psychologists (N=5)

Both child molesting samples involved the same subjects, tested once before any treatment and a second time eight weeks later after the victim impact section of therapy . (See Appendix B for treatment program timetable and contents.)

## VICTIM IMPACT SECTION 1 : OFFENDER ESTIMATIONS OF VICTIM AFFECT.

### 4.1. The accuracy of perspective taking when pertaining to victims.

There were three questions in particular that this section sought to answer:

1) Would offenders predict relatively accurately the feelings of their victims (as shown by a comparison to the predictions of professionals working with abused children)?

2) Would therapy influence offender predictions of victim impact?

3) Would age and gender of victim, and level of sexual contact involved, affect an offender's predictions of victim feelings?

The first question was investigated by examining each category of emotional response separately and using t-tests to determine significant differences between the scores of child molesters and professionals (see Appendix H for a list of these emotion categories).

Figures 2, 3 and 4, give a visual display of the differences in mean response from each subject group.

Figure 2.

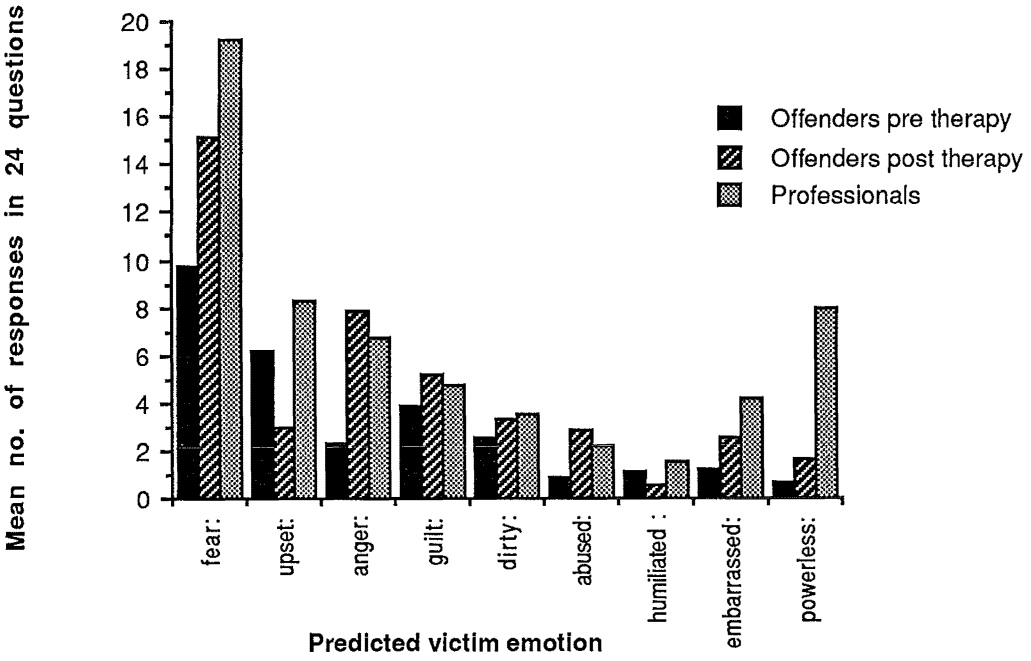



Figure 3.

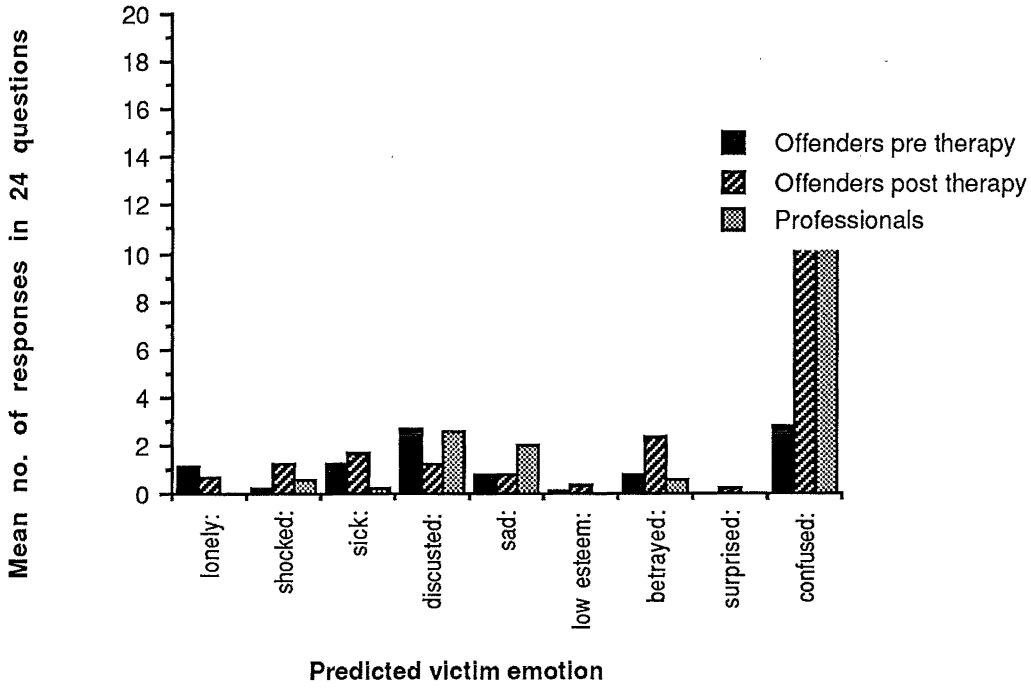
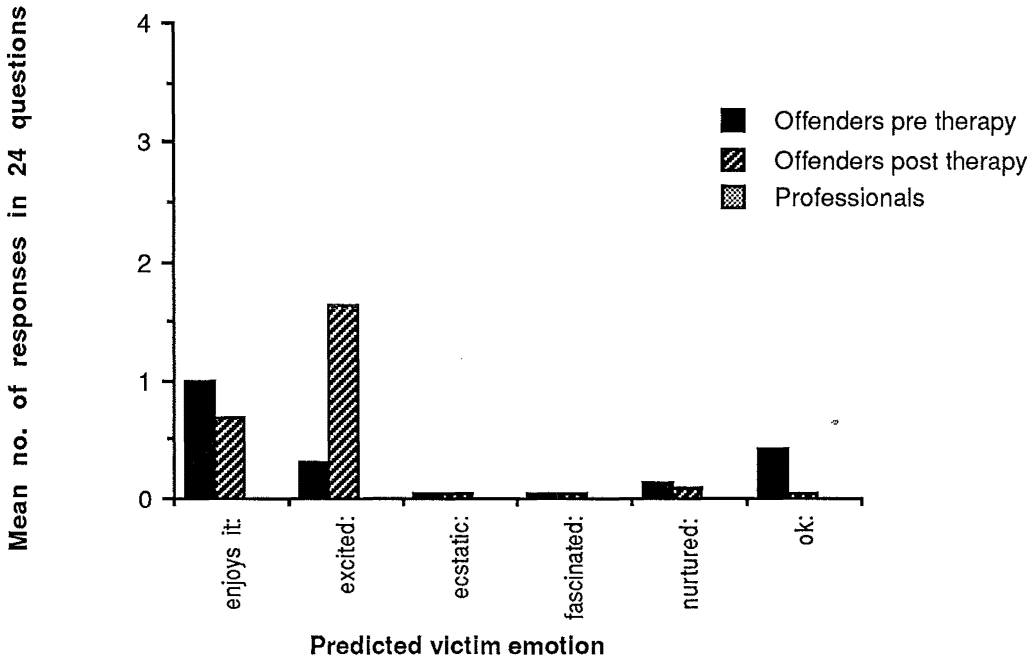


Figure 4.




### 4.1.1. Pre-therapy comparisons with professionals.

T-test comparisons between professionals and offenders before therapy, showed that significantly more professionals than offenders estimated that victims would feel:

fear***,
anger***,
abuse*,
powerlessness***,
sadness*,
shock*,
confusion***, and
arousal***.

* = $p < 0.05$
** = $p < 0.01$
*** = $p < 0.001$

No significant difference was found between groups for:

upset,
guilt,
dirty feelings,
humiliation,
embarrassment,
disgust,
betrayal,
low esteem,
loneliness and
sick feelings.

Scores for positive feelings such as enjoyment, affection, fascination, excitement, nurture, ecstasy, and neutral feelings such as surprise, were negligible for both groups (0 for professionals, <0.5 for offenders).

### 4.1.2. Post-therapy comparisons with professionals.

Comparisons between professionals and offenders after therapy, show that significantly more professionals estimated that victims would feel:

fear**,
upset***,
humiliation***,
powerlessness***,
disgust*,
sadness* and
arousal**,

and that significantly more offenders believed that victims will feel:

enjoyment*
and excitement*.

* = $p < 0.05$
** = $p < 0.01$
*** = $p < 0.001$

No difference was found between groups for :

anger,
guilt,
dirty feelings,
feelings of abuse,
embarrassment,
betrayal,
low esteem,
loneliness,
shock,
confusion and
sick feelings.

Scores for positive feelings such as affection, fascination, nurture, ecstasy, and neutral feelings such as surprise, were negligible for both groups (0 for professionals, <0.5 for offenders).

## 4.2. The effect of therapy.

The second question "Does therapy influence offender predictions of victim impact?", was investigated in two ways. Firstly differences in the frequency of individual emotions were measured before and after therapy, and secondly an analysis of the variance of scenario responses was completed, using pre- and post-therapy as one within group variable (see section 4.3.1. for anova results.)

### 4.2.1. T-Test comparisons between pre- and post-therapy molester responses.

Significant increases from pre- to post-therapy in offender estimations of victim emotions were found for:

fear**,
anger**,
abuse*, and
confusion***.

Graphs showing the frequency distribution of all three groups responses for each emotion can be found in Appendix L.

### 4..3. The influence of therapy, level of sexual contact with victim, and age and gender of victim.

The second and third questions (i.e. "Do offender predictions differ with age, gender and level of sexual contact with victim?" and "Are predictions affected by therapy?") were investigated using analyses of variance, with four within subject variables i.e. age (<6, 7-11, >12), gender (male, female), interaction (fondling, masturbation, penetration, force) and therapy (before, after), and no between-subject variables. The most common response clusters (i.e. negative emotions, positive emotions, neutral emotions, fear, upset and anger) were analyzed to see if any significant fluctuations in offender predictions of feelings occurred with these within subject variables.

More specifically, the categories examined were:

- -Negative emotions (a general category including all emotions not classed as neutral or positive (see Appendix H for details)
- -Positive emotions (a general category including all emotions not classed as neutral or negative (see Appendix H for details).
- -Fear,
- -Anger and
- -Upset

Further categories such as arousal, helplessness etc. contained too few responses for an analysis to render significant results.

#### 4.3.1. Anova Results.

Given the small number of subjects and hence the pilot nature of this investigation, interpretation of the analyses of variance was limited to main effects and two way interactions.

**(i). Negative Emotions.**

Age was found to have a significant effect on the amount of negative emotion predicted to be experienced by victims, ($F(2,20)=13.96$, $p<0.001$). Victims older than 12 years of age were predicted to have significantly more unpleasant feelings than both 7-11 year old victims ($p<0.01$) and victims less than 6 years ($p<0.01$). See Table 12 for means.

Table 12. Mean frequency of predicted negative emotions per scenario for the three age groups of victims.

| Victims age: | Mean frequency of predicted negative emotions per question: |
|---|---|
| < 6 years | 1.57 |
| 7-11 years | 2.21 |
| > 12 years | 2.36 |

There were also two significant interaction effects; those of gender/age/sexual contact ($F(6,60)=2.804$, $p<0.05$) and gender/age/therapy category/sexual contact ($F(6,60)=2.427$, $p<0.05$). See Table 13 for summary of negative emotion anova results.

Table 13. Summary of negative emotion anova results.

| | df | Sum of Squares | Mean Square | F | p | Epsilon Correction |
|---|---|---|---|---|---|---|
| Subjects | 10 | 57.932 | 5.793 | | | |
| G | 1 | .684 | .684 | .268 | .6162 | |
| Error | 10 | 25.545 | 2.555 | | | 1.00 |
| A | 2 | 62.057 | 31.028 | 13.963 | .0002 | |
| Error | 20 | 44.443 | 2.222 | | | .87 |
| GA | 2 | 1.777 | .888 | .461 | .6373 | |
| Error | 20 | 38.557 | 1.928 | | | .80 |
| T | 1 | 11.820 | 11.820 | 1.384 | .2667 | |
| Error | 10 | 85.409 | 8.541 | | | 1.00 |
| GT | 1 | .426 | .426 | .300 | .5961 | |
| Error | 10 | 14.220 | 1.422 | | | 1.00 |
| AT | 2 | 10.390 | 5.195 | 1.454 | .2572 | |
| Error | 20 | 71.443 | 3.572 | | | .98 |
| GAT | 2 | 4.534 | 2.267 | 1.641 | .2189 | |
| Error | 20 | 27.633 | 1.382 | | | .57 |
| C | 3 | 15.233 | 5.078 | 2.588 | .0714 | |
| Error | 30 | 58.871 | 1.962 | | | .62 |
| GC | 3 | 3.778 | 1.259 | .629 | .6020 | |
| Error | 30 | 60.076 | 2.003 | | | .63 |
| AC | 6 | 21.534 | 3.589 | 1.746 | .1258 | |
| Error | 60 | 123.299 | 2.055 | | | .40 |
| GAC | 6 | 29.420 | 4.903 | 2.804 | .0180 | |
| Error | 60 | 104.913 | 1.749 | | | .40 |
| TC | 3 | 6.642 | 2.214 | 1.135 | .3509 | |
| Error | 30 | 58.545 | 1.952 | | | .56 |
| GTC | 3 | 7.703 | 2.568 | 1.132 | .3521 | |
| Error | 30 | 68.068 | 2.269 | | | .59 |
| ATC | 6 | 14.170 | 2.362 | 1.881 | .0989 | |
| Error | 60 | 75.330 | 1.255 | | | .42 |
| GATC | 6 | 20.542 | 3.424 | 2.427 | .0363 | |
| Error | 60 | 84.625 | 1.410 | | | .37 |

Table Legend:
G=gender, A=age, T= therapy (pre or post), C= Sexual contact.

**(ii). Positive emotions.**

An anova of positive emotions showed no significant effects. See Table 14 for positive emotion anova results.

Table 14. Summary of positive emotion anova results.

| | df | Sum of Squares | Mean Square | F | p | Epsilon Correction |
|---|---|---|---|---|---|---|
| Subjects | 8 | 2.042 | .255 | | | |
| G | 1 | .058 | .058 | .917 | .3662 | |
| Error | 8 | .505 | .063 | | | 1.00 |
| A | 2 | .347 | .174 | 2.703 | .0974 | |
| Error | 16 | 1.028 | .064 | | | .61 |
| GA | 2 | .005 | .002 | .308 | .7394 | |
| Error | 16 | .120 | .008 | | | .73 |
| T | 1 | .002 | .002 | .006 | .9399 | |
| Error | 8 | 3.060 | .383 | | | 1.00 |
| GT | 1 | .058 | .058 | .917 | .3662 | |
| Error | 8 | .505 | .063 | | | 1.00 |
| AT | 2 | .005 | .002 | .027 | .9734 | |
| Error | 16 | 1.370 | .086 | | | .60 |
| GAT | 2 | .032 | .016 | 2.800 | .0906 | |
| Error | 16 | .093 | .006 | | | .84 |
| C | 3 | .211 | .070 | 1.474 | .2468 | |
| Error | 24 | 1.144 | .048 | | | .51 |
| GC | 3 | .100 | .033 | 1.890 | .1582 | |
| Error | 24 | .421 | .018 | | | .64 |
| AC | 6 | .171 | .029 | 1.065 | .3967 | |
| Error | 48 | 1.287 | .027 | | | .41 |
| GAC | 6 | .144 | .024 | .605 | .7251 | |
| Error | 48 | 1.898 | .040 | | | .31 |
| TC | 3 | .266 | .089 | 1.957 | .1473 | |
| Error | 24 | 1.088 | .045 | | | .53 |
| GTC | 3 | .025 | .008 | .411 | .7464 | |
| Error | 24 | .495 | .021 | | | .68 |
| ATC | 6 | .255 | .042 | 1.692 | .1433 | |
| Error | 48 | 1.204 | .025 | | | .41 |
| GATC | 6 | .079 | .013 | .321 | .9230 | |
| Error | 48 | 1.963 | .041 | | | .32 |

Table Legend:

G=gender, A=age, T=therapy (pre or post), C= Sexual contact.

**(iii). Fear.**

An anova of the fear that child molesters predicted victims would experience, showed significant effects of

| | |
|---|---|
| gender, | (F(1,10)=8.12, p<0.01) |
| age | (F(2,20)=4.54, p<0.05) |
| sexual contact | (F(3,30)=3.43, p<0.05), and |
| therapy | (F(1,10)=8.83, p<0.05). |

Gender:

Females were significantly more likely to be predicted to be fearful than males (p<0.05). See Table 16 for mean scores.

Table 16. Mean frequency of predicted fear emotion per scenario for the two genders of victim.

| Gender: | Mean frequency of predicted fear emotions per question: | |
|---|---|---|
| female | 0.8523 | (i.e., 85% of victims estimated to be fearful) |
| male | 0.6174 | (i.e., 62% of victims estimated to be fearful) |

Age:

Victims aged 7-11 were predicted to be more scared than those older than 12 years (p<0.01). See Table 17 for mean scores.

Table 17. Mean frequency of predicted fear emotion per scenario for the three ages of victims.

| Age: | means: | |
|---|---|---|
| <6 | 0.7380 | (i.e., 73% fearful) |
| 7-11 | 0.8750 | (i.e., 87% " ) |
| >12 | 0.5909 | (i.e., 59% " ) |

Therapy:

Victims were predicted to have a greater amount of fear by child molesters after those child molesters had completed therapy ($p<0.05$). See Table 18 for mean scores.

Table 18. Mean frequency of predicted fear emotion per scenario for the three ages of victims.

| | mean amount of fear predicted: |
|---|---|
| pre therapy | 0.4621 |
| post therapy | 1.0076 |

Sexual contact:

Child molesters predicted that victims would show significantly different amounts of fear between fondling and penetration ($p<0.01$) and between penetration and force ($p<0.01$). See Table 19 for mean scores.

Table 19. Mean frequency of predicted fear emotion per scenario for the four levels of sexual contact with victim.

| Level of sexual contact: | Mean fear response |
|---|---|
| Fondling | 0.6818 |
| Masturbation | 0.7273 |
| Penetration | 0.8939 |
| Force | 0.6364 |

See Table 20 for the fear anova summary table.

Table 20. Fear Anova Summary Table.

| | df | Sum of Squares | Mean Square | F | p | Epsilon Correction |
|---|---|---|---|---|---|---|
| Subjects | 10 | 116.129 | 11.613 | | | |
| G | 1 | 7.280 | 7.280 | 8.117 | .0173 | |
| Error | 10 | 8.970 | .897 | | | 1.00 |
| A | 2 | 7.106 | 3.553 | 4.542 | .0236 | |
| Error | 20 | 15.644 | .782 | | | .87 |
| GA | 2 | 1.879 | .939 | 2.838 | .0823 | |
| Error | 20 | 6.621 | .331 | | | .67 |
| T | 1 | 39.273 | 39.273 | 8.830 | .0140 | |
| Error | 10 | 44.477 | 4.448 | | | 1.00 |
| GT | 1 | 1.280 | 1.280 | 2.272 | .1627 | |
| Error | 10 | 5.636 | .564 | | | 1.00 |
| AT | 2 | 2.591 | 1.295 | 2.550 | .1031 | |
| Error | 20 | 10.159 | .508 | | | .84 |
| GAT | 2 | .424 | .212 | .285 | .7553 | |
| Error | 20 | 14.909 | .745 | | | .70 |
| C | 3 | 5.000 | 1.667 | 3.429 | .0295 | |
| Error | 30 | 14.583 | .486 | | | .89 |
| GC | 3 | .386 | .129 | .405 | .7502 | |
| Error | 30 | 9.530 | .318 | | | .76 |
| AC | 6 | 4.500 | .750 | 1.504 | .1923 | |
| Error | 60 | 29.917 | .499 | | | .54 |
| GAC | 6 | 4.545 | .758 | 1.142 | .3492 | |
| Error | 60 | 39.788 | .663 | | | .63 |
| TC | 3 | 1.515 | .505 | .617 | .6096 | |
| Error | 30 | 24.568 | .819 | | | .77 |
| GTC | 3 | .447 | .149 | .379 | .7690 | |

| | | | | | |
|---|---|---|---|---|---|
| Error | 30 | 11.803 | .393 | | .77 |
| ATC | 6 | 4.439 | .740 | 1.201 | .3185 |
| Error | 60 | 36.977 | .616 | | .65 |
| GATC | 6 | 3.303 | .551 | 1.131 | .3554 |
| Error | 60 | 29.197 | .487 | | .64 |

Table Legend:
G=gender, A=age, T=therapy (pre or post), C= Sexual contact.

**(iv). Anger.**

An analysis of variance of the anger responses predicted by child molesters to be experienced by their victims, showed significant effects of :-

age ($F(2,20)=5.84$, $p<0.01$)
therapy ($F(1,10)=8.85$, $p<0.05$)
sexual contact ($F(3,30)=11.37$, $p<0.001$), and
gender/age/therapy/sexual contact ($F(6,600)=3.18$, $p<0.01$)

Age:

Victims aged 7-11 were estimated by child molesters to be significantly more angry than victims aged less than 6 years ($p<0.01$), and victims older than 12 years were also predicted to be significantly more angry than those aged less than 6 years ($p<0.01$). See Table 21 for mean scores.

Table 21. Mean frequency of predicted anger per scenario for the three age groups of victim.

| age | means |
|---|---|
| <6 | 0.1136 |
| 7-11 | 0.2500 |
| >12 | 0.3125 |

Therapy:

After therapy, offender estimates of victim anger rose significantly ($p<0.01$). See Table 22 for mean scores.

Table 22. Mean frequency of predicted anger per scenario both before therapy and after therapy.

| | Mean |
|---|---|
| Before therapy | 0.0985 |
| After therapy | 0.3523 |

Sexual contact:

Force was estimated to cause significantly more anger than every other type of sexual contact ($p<0.01$ in every case). See Table 23 for mean scores.

Table 23. Mean frequency of predicted anger per scenario for the four levels of sexual contact with victim.

| Sexual contact: | Mean:: |
|---|---|
| fondling | 0.1212 |
| masturbation | 0.1894 |
| penetration | 0.2121 |
| force | 0.3788 |

See Table 24 for the anger anova summary table.

Table 24. Anger Anova Summary Table.

| | df | Sum of Squares | Mean Square | F | p | Epsilon Correction |
|---|---|---|---|---|---|---|
| Subjects | 10 | 11.367 | 1.137 | | | |
| G | 1 | .153 | .153 | 1.000 | .3409 | |
| Error | 10 | 1.534 | .153 | | | 1.00 |
| A | 2 | 3.640 | 1.820 | 5.838 | .0101 | |
| Error | 20 | 6.235 | .312 | | | .64 |
| GA | 2 | .034 | .017 | .185 | .8324 | |
| Error | 20 | 1.841 | .092 | | | .94 |
| T | 1 | 8.502 | 8.502 | 8.854 | .0139 | |
| Error | 10 | 9.602 | .960 | | | 1.00 |
| GT | 1 | .229 | .229 | 1.667 | .2258 | |
| Error | 10 | 1.375 | .138 | | | 1.00 |
| AT | 2 | .936 | .468 | 3.374 | .0546 | |
| Error | 20 | 2.773 | .139 | | | .57 |
| GAT | 2 | .027 | .013 | .158 | .8552 | |
| Error | 20 | 1.682 | .084 | | | .80 |
| C | 3 | 4.733 | 1.578 | 11.369 | .0000 | |
| Error | 30 | 4.163 | .139 | | | .59 |
| GC | 3 | .854 | .285 | 2.662 | .0659 | |
| Error | 30 | 3.208 | .107 | | | .71 |
| AC | 6 | .420 | .070 | .863 | .5272 | |
| Error | 60 | 4.871 | .081 | | | .64 |
| GAC | 6 | .481 | .080 | 1.161 | .3393 | |
| Error | 60 | 4.144 | .069 | | | .56 |
| TC | 3 | .930 | .310 | 2.297 | .0978 | |
| Error | 30 | 4.049 | .135 | | | .68 |
| GTC | 3 | .415 | .138 | 1.112 | .3598 | |
| Error | 30 | 3.731 | .124 | | | .58 |
| ATC | 6 | .519 | .086 | 1.317 | .2635 | |
| Error | 60 | 3.939 | .066 | | | .63 |
| GATC | 6 | 1.398 | .233 | 3.181 | .0089 | |
| Error | 60 | 4.394 | .073 | | | .54 |

Table Legend:

G=gender, A=age, T=therapy (pre or post), C= Sexual contact.

**(v). Upset.**

This analysis of variance revealed two significant results: those for the level of sexual contact ($F(3,30)=3.685$, $p<0.05$)), and for the gender/therapy interaction ($F(1,10)=7.824$, $p<0.05$)).

Level of sexual contact:

There is a significant difference in predicted upset feelings between fondling and penetration ($p<0.05$) and also a significant difference in predicted upset feelings between fondling and force ($p<0.01$). See Table 25 for mean scores.

Table 25. Mean frequency of predicted upset feelings per scenario for the four levels of sexual contact with victim.

| Level of sexual contact: | Means: |
|---|---|
| fondling | 0.2652 |
| masturbation | 0.3106 |
| penetration | 0.3636 |
| force | 0.3864 |

Gender/Therapy:

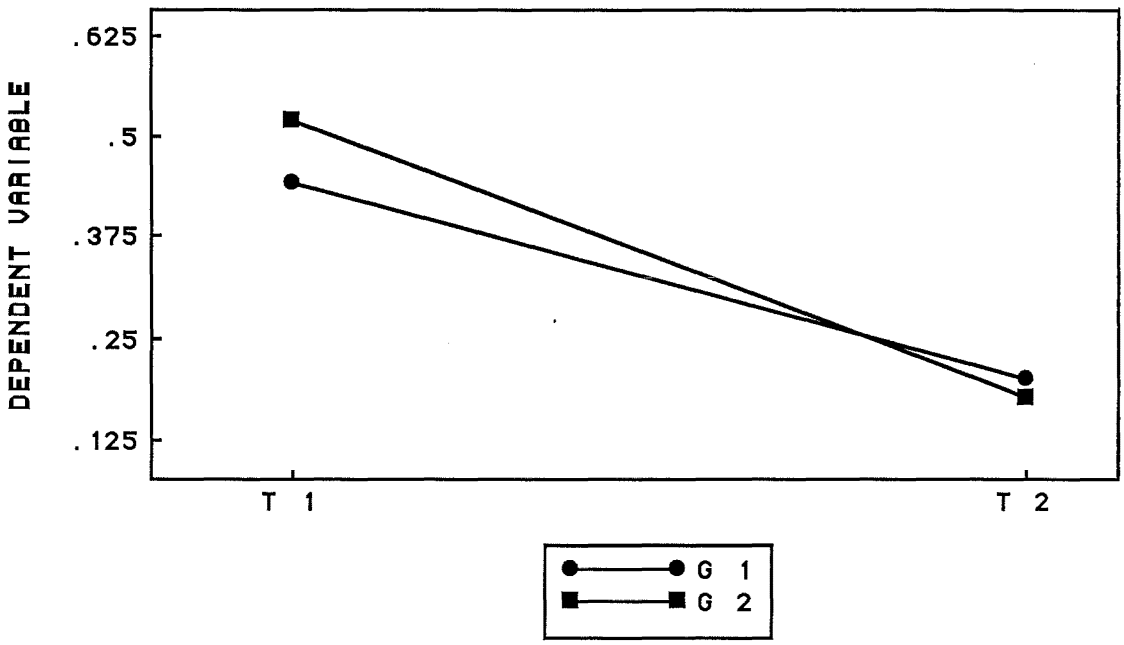
Subjects predicted significantly less upset in male victims after they had undergone therapy than predictions of either male or female victim upset before therapy ($p<0.01$ in both cases). Similarly, subjects predicted significantly less upset in female victims after they had undergone therapy than predictions of either male or female victim upset before therapy (again $p<0.01$ in both cases). See Table 26 for mean scores.

Table 26. Mean frequency of predicted upset feelings per scenario for male and female victims before and after therapy.

| Offender prediction of upset: | Mean |
|---|---|
| male victim, estimation before therapy | 0.5152 |
| female victim, estimation before therapy | 0.4394 |
| male victim, estimation after therapy | 0.1742 |
| female victim, estimation after therapy | 0.1970 |

Figure 5 shows the gender/therapy interaction, with an overall drop in both female and male upset predictions from before therapy to after therapy, and a change in gender for highest mean score from before therapy to after therapy.

Figure 5. The gender/therapy interaction.




Where:
Dependent variable = prediction of upset emotions in victim.
G1 = Female victims
G2 = Male victims
T1 = Before therapy
T2 = After therapy

Table 27. Upset anova summary table

| | df | Sum of Squares | Mean Square | F | p | Epsilon Correction |
|---|---|---|---|---|---|---|
| Subjects | 10 | 18.061 | 1.806 | | | |
| G | 1 | .093 | .093 | .712 | .4184 | |
| Error | 10 | 1.303 | .130 | | | 1.00 |
| A | 2 | .299 | .150 | .837 | .4477 | |
| Error | 20 | 3.576 | .179 | | | .67 |
| GA | 2 | .254 | .127 | 1.109 | .3493 | |
| Error | 20 | 2.288 | .114 | | | .84 |
| T | 1 | 11.229 | 11.229 | 3.527 | .0898 | |
| Error | 10 | 31.833 | 3.183 | | | 1.00 |
| GT | 1 | .320 | .320 | 7.824 | .0189 | |
| Error | 10 | .409 | .041 | | | 1.00 |
| AT | 2 | .367 | .184 | 1.830 | .1862 | |
| Error | 20 | 2.008 | .100 | | | .76 |
| GAT | 2 | .140 | .070 | .678 | .5191 | |
| Error | 20 | 2.068 | .103 | | | .99 |
| C | 3 | 1.172 | .391 | 3.685 | .0227 | |
| Error | 30 | 3.182 | .106 | | | .74 |
| GC | 3 | .536 | .179 | 1.404 | .2609 | |
| Error | 30 | 3.818 | .127 | | | .68 |
| AC | 6 | .277 | .046 | .487 | .8157 | |
| Error | 60 | 5.682 | .095 | | | .60 |
| GAC | 6 | .231 | .039 | .489 | .8142 | |
| Error | 60 | 4.727 | .079 | | | .66 |
| TC | 3 | .066 | .022 | .224 | .8787 | |
| Error | 30 | 2.955 | .098 | | | .63 |
| GTC | 3 | 1.339 | .446 | 2.504 | .0782 | |
| Error | 30 | 5.348 | .178 | | | .71 |
| ATC | 6 | .814 | .136 | 1.167 | .3359 | |
| Error | 60 | 6.977 | .116 | | | .49 |
| GATC | 6 | .223 | .037 | .414 | .8671 | |
| Error | 60 | 5.402 | .090 | | | .58 |

Table Legend:

G=gender, A=age, T=therapy (pre or post), C= Sexual contact.

## VICTIM IMPACT SECTION 2 : OFFENDER AFFECT CONCERNING SCENARIOS.

### 4.4. Offender affect response categories.

In order to assess the empathetic concern and personal distress of offenders when they are specifically relating to child victims of sexual abuse, an analysis was made of the responses to the second half of each of the twenty-four scenarios ("How do you feel?"). Offender feelings were divided into twelve categories based on the responses that were given.
These were

guilt
sexual arousal
fear
good feelings
good and bad feelings (a mixture of pleasant and unpleasant affect)
good during molestation, bad afterwards
neutral
bad (i.e., unpleasant)
concerned for victim
morality-OK (an indication of acceptability or "rightness" of act)
morality-not OK (an indication of "wrongness" of act)
can't stop
don't know (how I feel)
wouldn't do it

Only subjects who answered over three quarters of all questions were used in this analysis, resulting in 18 pre-therapy subjects and 15 post-therapy subjects.

#### 4.4.1.Percentage of subjects mentioning each category.

Firstly the percentage of subjects mentioning one of the above categories at any stage during the questionnaire was calculated. Responses were tallied both before and after therapy to

investigate changes in these percentages. A chi-squared analysis revealed that the number of subjects mentioning guilt, concern for victim, "good and bad" feelings, "good during, bad after" feelings, neutral feelings and "morality - not OK" increased significantly with therapy. See Table 27 for the percentages and the significance of differences between pre- and post-therapy responses.

Table 27. The percentage of subjects who mention a category at any stage during the questionnaire.

| Category: | % of subjects mentioning category at any time in 24 scenarios: | | |
|---|---|---|---|
| | % Pre therapy | % Post therapy | Sig. |
| Guilt | 55.6 | 93.3 | *** |
| Arousal | 50 | 53.3 | |
| Fear | 55.6 | 60.0 | |
| Good | 44.4 | 33.3 | |
| Good and bad | 16.6 | 53.3 | *** |
| good during, bad after | 16.6 | 33.3 | ** |
| neutral | 16.6 | 33.3 | ** |
| bad | 100 | 100 | |
| concerned for victim | 0 | 46.7 | *** |
| Morality-OK | 5.6 | 0 | * |
| Morality -not OK | 44.4 | 60.0 | * |
| can't stop | 22.2 | 26.7 | |
| don't know | 50 | 6.7 | *** |
| wouldn't do it | 88.8 | 20 | *** |
| no answer | 29.6 | 70 | *** |

* = $p<0.05$
** = $p<0.01$
*** = $p<0.001$

### 4.4.2. Mean response levels for each category.

The mean frequency of subject responses for each category in twenty four scenarios was calculated, and the significance of changes from pre- to post-therapy determined. See Table 28 for mean scores.

Table 28. Mean response rate for each category over 24 scenarios.

| | Pre therapy | | Post therapy | | Sig. |
|---|---|---|---|---|---|
| | Mean | SD | Mean | SD | |
| Guilt | 4.18 | (7.71) | 5.41 | (8.11) | |
| Arousal | 2.19 | (5.63) | 2.63 | (5.72) | |
| Fear | 2.04 | (5.14) | 2.07 | (5.23) | |
| Good | 2.78 | (5.95) | 1.59 | (4.05) | |
| Good and bad | 0.19 | (0.56) | 0.96 | (2.23) | |
| good during, bad after | 0.11 | (0.32) | 0.3 | (0.72) | |
| neutral | 0.33 | (1.11) | 0.59 | (1.78) | |
| bad | 11.26 | (10.02) | 10.15 | (10.53) | |
| concerned for victim | 0 | (0) | 2.74 | (5.81) | |
| Morality-OK | 0 | (0) | 0 | (0) | |
| Morality -not OK | 1.41 | (3.72) | 1.85 | (3.24) | |
| can't stop | 0.22 | (0.64) | 0.26 | (0.71) | |
| don't know | 2.7 | (6.33) | 0.037 | (0.19) | * |
| wouldn't do it | 3.22 | (4.53) | 0.48 | (1.81) | |
| no answer | 2.22 | (5.54) | 7.37 | (10.33) | * |

* = $p < 0.05$

### 4.5. The influence of therapy on mean response levels.

A chi-squared analysis of these means showed no significant difference from pre- to post-therapy in any of the above categories. A paired t-test of all individual subject scores before

and after therapy showed only a significant drop in "don't know" and a significant increase in "no answer" categories.

Graphs showing the frequency distributions of these responses can be found in Appendix M.

An intended analysis of the variance of these categories over age, gender and level of sexual contact had to be abandoned because of the high level of sporadic missing data. This point will be addressed in the discussion section.

Because of the free response nature of this questionnaire, there were several interesting but uncommon (and therefore statistically non-significant) answers that fell outside the established categories. These have been put in Appendix N and will be referred to in the discussion section.

# CHAPTER FOUR

# DISCUSSION

## 1. COGNITIVE DISTORTIONS.

### 1.1 DISCUSSION OF RESULTS.

As expected, all child molester samples showed significantly more cognitive distorting than a contrast group of students. This supports Abel and Becker's conclusions that this phenomenon is more prevalent in child molesters than in the general population. Further, it seems that cognitive behavioural therapy indeed reduces distortions and minimisations. Molesters, after therapy, were not significantly different from student contrasts in their ABCDQ. scores. These findings support the efficacy of cognitive treatment for child molesters to expose and normalise distortions.

#### 1.1.1. Treatment Vs Non-treatment controls.

The initial hypothesis, that a significant difference would be found between non treatment child molester controls and the treatment group before therapy was not supported. Non-treatment subjects did not show significantly more distortion than the pre-treatment therapy group subjects. This hypothesis arose from the idea that non-treatment child molester controls would have chosen not to undergo therapy because they did not believe that they were in need of help. However, questioning of these subjects revealed that this assumption was generally false. Most non treatment subjects (i.e., those not at the Kia Marama Sex offenders unit) were either ineligible (e.g., they were due for release), or were about to begin the treatment program at the next intake. Many were involved in a therapy group at their own prison (involving some distortion work), and those who expressed a reluctance to go to Kia Marama did so for reasons other than those expected (e.g., some imagined that the course involved very unpleasant aversion therapy techniques such as electric shock treatment, which they understandably wanted to avoid). Given this, and the fact that both

samples were drawn initially from the same prison situations, it is not surprising that the same levels of distortion were found.

### 1.1.2. Non-treatment Vs Post-therapy treatment.

Non treatment group scores also showed no significant difference from those of the treatment group after therapy, indicating that non treatment scores lie between pre-treatment and post-treatment scores. These differences are not significant, but this point may be of interest to those doing further research in the area.

### 1.1.3. First year treatment Vs Second year treatment.

Somewhat less expected are the differences between first year subjects just after cognitive therapy and second year subjects, who completed cognitive therapy in their first year. The two samples were initially predicted to show similar reductions in distortion, however this was not the case. The second years showed distortion scores as high as those of first years prior to therapy. It is difficult to determine whether the low second year scores resulted from an increase in distortions over time since the previous years training, or whether this group had low scores to begin with, as no distortion data was gathered for this group before the current study. It is highly possible that these men, the first to enter the training program, were amongst the more difficult, dangerous and extreme, of the child molesters in prison at the time. As it is frequently the case that these "worst" offenders are the first to be selected for treatment.

However this result also raises the issue of stability of therapy results over time. It is possible that positive benefits eventually decay causing the reappearance of distorted attitudes and beliefs. If this is the case then follow-up treatment, such as a mini relapse prevention program may be of value. This issue must be explored and addressed so that the ultimate temporal stability can be achieved.

### 1.1.4. Pre treatment Vs Pre caught.

A further hypothesis was that scores before therapy would be significantly less distorted than those estimated by subjects to be their responses before being caught or brought to the attention of authorities. Results revealed that, as predicted, distortions were significantly greater at the earlier stage. A number of interpretations concerning this result are possible. It may indicate that social opinions (after being caught) are a significant variable in influencing offender attitudes and beliefs, or offender knowledge of socially desirable responses. It may also indicate a tendency to admit to past beliefs more easily than present ones (since demands to change are strong in the environment at Kia Marama). These possibilities remain to be investigated.

## 1.2. PROBLEMS WITH THE ABCDQ.

The Abel and Becker Cognitions Scale is currently the only published scale that specifically measures the cognitive distortions of child molesters. Unfortunately it has several important limitations. An obvious one is the lack of question reversal. Subjects score all questions from one - a distorted response, to five - a non distorted response. This problem would be reduced by changing the direction of half the questions.

Another problem was the strong influence of social desirability in this scale. Salter (1984) believed that social desirability should be of little influence in the ABCDQ scale since offenders were unaware of their distortions. However the author disagrees to a certain extent with Salters' hypothesis. It was obvious to many students (from discussions afterwards) that the "correct" answer to each question was five. Therefore it is highly likely that molesters were also influenced to some extent. Socially desirable answers are sure to have become apparent to molesters during their exposure to strong public opinion after being caught. Although offender scores indicated that they did not recognise the social desirability of answers to the extent that students did, they still appeared to answer questions in a more socially desirable way (i.e., less distorted) than the author expected (as indicated in

Abel et al., 1989). Only two of twenty nine questions averaged below a score of three (neutral)(See Appendix K for details). This means that child molesters in this study indicated disagreement with almost all the cognitive distortions outlined. This finding directly contrasts therapy session instances where distortions were frequently obvious. Thus it seems that there was at least some influence causing subjects to modify their distortions in a socially desirable way in this questionnaire. Ways of reducing the influence of social desirability factors will be outlined later in this section.

It is possible that social desirability was also involved in the finding that estimation of beliefs pre-therapy was contrasted to estimation of attitude prior to capture (as already mentioned).

A third problem concerns the ambiguity of many questions. (See Appendix K). The answer to these depends on the understanding of question meaning. This openness to individual interpretation makes responses more difficult to assess. Examples of ambiguity are phrases such as:

| | | |
|---|---|---|
| "likes" | (Q1) | -enjoys sexuality, or is curious? |
| "learns how to relate" | (Q9) | -is this sexually, socially, normally? |
| "An adult can tell" | (Q13) | -this could mean either "can tell that it definitely would" or just "can tell from the situation either way |
| "feeling a child's body" | (Q14) | -sexually or platonically? |
| "fondling" | (Q17) | -sexually or platonically? |
| "harm" | (Q10 and 17) | -is this physical or mental situational of permanent? |

Questions such as numbers 13 and 19 (e.g., 19: "My daughter (son) or other young child knows that I will still love her (him) even if she (he) refuses to be sexual with me.") were particularly ambiguous and tended to be strongly agreed with by many non-offenders (particularly women in a pilot student survey by the author). This ambiguity meant that an analysis of each question's

mean response (Appendix K) showed differences that were potentially due not only to the distortions present but also to the ambiguity of the question. (All subject groups showed especially large changes in mean scores on questions that were ambiguous). Therefore it was impossible using this scale, to accurately determine the popularity and frequency of specific distortions in this offending population.

An additional problem with the ABCDQ was the influence of particular wording on the response given. A concurrent pilot study (Morgan, 1991) indicated that the use of the third person ("an adult") rather than the first ("I") increased an offender's likelihood of agreeing with a statement (the apparent removal of a personal connection possibly increasing honesty). This again confirms that social desirability is an influence in the answering of this questionnaire.

To conclude, question reversal, a reduction in ambiguity, a removal of personal pronouns, and an inclusion of a test for social desirability influences may make this scale a more accurate measure of the cognitive distortions of child molesters.

### 1.3. BRIEF SUMMARY OF ABCDQ FINDINGS.

In summary, cognitive distortions were more prevalent in child molesters than in a student contrast group. Distortions were rated as strongest before capture but diminished to a level equivalent to that of the student contrast group directly after therapy. A sample of child molesters in their second year of treatment displayed distortion levels as high as those of pre-treatment groups. Several possible refinements to this measurement have been outlined. All can easily be applied.

## 2. EMOTIONAL AWARENESS.

### 2.1. DISCUSSION OF RESULTS.

Levels of emotional awareness amongst the child molesters involved in this study were significantly lower than in a contrast

group of non criminals (Curtis, 1990). However, as no other study thus far has explored emotional awareness in child molesters, this preliminary finding is inconclusive. In contrast to this result, Curtis' (1990) investigation comparing rapists with the same non-criminal control group found no significant difference in levels of emotional awareness. It is possible then, that child molesters have greater deficits in emotional awareness than other types of sexual offenders. Both non-violent and violent offenders (Curtis, 1990) were found to be as low as the child molesters in the current study. Curtis relates this finding to the under-development of emotional control in some violent offenders (Heilbrun Jr., 1979; Megargee & Mendelsohn, 1962). She links this under-development to Lane and Schwartz's theory proposing that poor emotional impulse control is possibly related to lack of cognitive structural organisation of emotion arousal [see footnote]. However this link is speculative. There is thus far no adequate explanation for why child molesters, non-violent and violent offenders in particular, should be deficient in emotional awareness, when other types of sexual offenders are not. However this finding does parallel frequent reports in the literature that rapists show normal levels of attributes that are found to be abnormal in child molesters (e.g., cognitive distortions, social skills, patterns of sexual arousal).

Caution must be used in interpreting LEAS results, since reliability and validity data on the scale have not yet been published. Furthermore, each of Curtis' samples contain only ten

---

Lane and Schwartz believe that emotional arousal and experiences are assimilated into developing cognitive schemata, where differentiation and integration cause increasing internal awareness and regulation of emotional states. Less development therefore, should produce less emotional awareness and regulation.

subjects. Evaluation of the psychometric properties of the LEAS, and follow-up studies re-testing these findings, will help clarify whether these deficits do occur, and to what extent. Studies investigating the developmental stages of emotional awareness will also be of considerable benefit in the understanding of this complex phenomenon and it's relationship to anti-social behaviour.

### 2.1.1. Correlations between the LEAS and IRI subscales.

If Lane and Schwartz's theory of emotional development (outlined in Chp. 1, section 2.3.3.) is correct then it can be assumed that an individual would need both perspective taking ability and emotional awareness of the self, before being able to be either personally distressed by another's experiences, or concerned for another person (PT = perspective taking; PD = personal distress; EC = empathetic concern, on the Interpersonal Reactivity Index). In addition, if Davis (1983a) is correct, fantasy should also show a positive correlation.

These expectations were largely unsubstantiated by the results of this study. Perspective taking, the most likely of the proposed positive correlations, was instead significantly negatively correlated. Empathetic concern and fantasy were not correlated with emotional awareness at all. Personal distress was the only highly positively correlated result.

In addition to contrasting with Lane and Schwartz's theory, the first result also contradicts the findings of Sommers (1981) who found a positive correlation between range of emotions reported to be experienced and perspective taking ability. Davis (1983a), on the other hand, continually describes perspective taking as primarily a cognitive dimension, and finds few relationships between PT and emotionality (e.g., a negative correlation between PT and a fearfulness scale, and a correlation between PT and positive emotional experience). Davis does however find significant positive correlations between PT and EC - a dimension that is emotion based. This finding is to be expected according to Coke et al. (1978) who propose that adopting another's perspective should be associated with feelings of concern and

sympathy. The negative correlation in the current study therefore, differs from all previous findings of either no correlation or a positive correlation.

The second and third results (that empathetic concern and fantasy were not correlated with emotional awareness at all) contradict Davis' (1983a) findings that empathetic concern and fantasy are both related to emotionality, and also contradict those of Archer et al. (1981) who found a relationship between chronic emotionality and feelings of sympathy for a needy subject.

The final result (that personal distress was highly correlated with emotional awareness) again differs from predictions based on Lane and Schwartz theory (i.e., that perspective taking and empathetic concern must be present for personal distress to occur). However two studies, Davis, (1983a) and Archer et al., (1981) are in agreement with these results. Davis found a very strong association between personal distress and certain types of emotionality (e.g., fearfulness, uncertainty and vulnerability). Archer et al. found that chronic emotionality was associated with personal distress concerning a needy subject.
It is important to note however that this scale is not, strictly speaking a measure of emotionality, but rather a measure of the ability of the individual to discriminate and label affect. A person may feel emotions relatively intensely without necessarily being skilled at affect identification.

It is possible that the scores from this study differ from norms in the studies outlined above because of differences in the population being investigated here (child molesters). These differences will be investigated in the discussion of IRI results. It is also possible that the differences between expected and actual results in this study may have been due to the shortcomings of the theories outlined, or the limitations of the measurement used. Limitations observed by the author when using this scale were:

- the lack of normative data with which to make comparisons,
- the lack of data available concerning reliability and validity of the scale,

- the observation that some subjects were aware of their emotions (as shown in later questionnaires) but chose to respond only with thoughts or actions, giving an inaccurate estimate,
- the limitations of a written response questionnaire when administered to those of low verbal ability. (There is the possibility that some subjects may experience emotions but have limited ability to communicate them either in writing or verbally. One example of this, alexithymia, or "no words for mood", is believed to interfere with an individual's capacity to express their emotions, despite their awareness of them.

The LEAS was not significantly correlated with level of cognitive distortion. This result is also surprising, since, according to Lane and Schwartz, conscious conflicts of emotional states are a typical feature of those with a stage five level of emotional awareness. It could be expected then that a positive correlation would be found between awareness and distortion. However, again, this was not the case.

If the LEAS is proven reliable and valid, and emotional awareness is found to be consistently linked to certain types of anti-social behaviour (as it has been in this study) then there are ramifications for the treatment of such offenders. Lane and Schwartz outline in detail the therapy procedures most appropriate for use with clients at each level of their emotional awareness scale. They believe that the success of techniques such as skills training and cognitive behavioural therapy are influenced greatly by a subjects level of emotional awareness. As both of these treatments are usually part of child molester therapy, this point may also be of significance for program success.

## 2.2. BRIEF SUMMARY OF EMOTIONAL AWARENESS FINDINGS.

Child molesters were significantly less emotionally aware (according to the LEAS) than either rapists or a non criminal control. Non-violent and violent controls showed comparable deficits to child molesters. More information concerning this relatively new phenomenon is necessary to enable satisfactory

explanations of these findings. Evaluation of psychometric properties of the LEAS is also important. Correlations between emotional awareness scores and empathy subscale scores differed from expectations based on Lane and Schwartz model of emotional awareness development. Perspective taking was negatively correlated with emotional awareness, and personal distress was positively correlated. Both EC and F do not correlate. Again, increased understanding of the nature and development of emotional awareness, and improved understanding of the psychometric properties of the LEAS, is necessary before conclusions can be drawn from these results.

# 3. EMPATHY.

## 3.1. DISCUSSION OF RESULTS.

The hypothesis that empathy scores in the treatment group would not change between pre- and post-therapy testing was proved correct, with no significant differences being recorded for any of the four empathy dimensions. This hypothesis was based on the speculation that therapy specifically focuses on victim empathy, therefore a scale recording general empathetic ability would not necessarily reflect victim empathy changes. Whether this speculation is accurate remains unknown.

### 3.1.1. Perspective taking.

The hypothesis that the perspective taking scores of child molesters would be equal if not greater than those of contrast groups was, on the whole, not supported. In fact, all child molester groups were significantly worse at perspective taking than factory workers. Child molesters (post-therapy) were also worse than students. Only child molesters before therapy and in their second year showed similar perspective taking scores to students.

### 3.1.2. Empathetic Concern.

The hypothesis that empathetic concern would be lower in child molesters than in contrast groups was also not supported. Instead scores were largely similar (no significant difference), the exception being a significantly lower child molester score after therapy than that of factory workers.

### 3.1.3. Fantasy.

The hypothesis that inmate fantasy scores would be greater or equivalent to contrasts was supported. Child molester scores were not greater, but showed no significant difference to those of factory workers. Child molester scores were even found to be slightly less than those of students in two groups.

### 3.1.4. Personal Distress.

The hypothesis that child molesters would show less personal distress than contrast groups was totally inaccurate in every case. All but two of six comparisons showed no significant difference in scores. The remainder indicated that students in fact showed less personal distress than offenders.

## 3.2. BRIEF SUMMARY OF EMPATHY FINDINGS.

To summarise then, perspective taking ability proved to be the most common deficit in child molesters when compared to contrasts, with signicant differences found in four of six group comparisons. Only one of six comparisons showed lacks in the empathetic concern of child molesters, and only two of six showed lower fantasising ability. Personal distress was actually higher in child molesters than in student contrasts in two of six correlations.

According to this study then, incarcerated child molesters are capable of showing normal amounts of empathetic concern, fantasising ability and personal distress, but possibly have

deficits in their tendency to take the perspective of others. It is important to note that these findings refer to general empathetic ability, and not to empathy for child victims of sexual abuse. The latter is outlined later.

## 3.3. COMPARISON OF RESULTS TO PREVIOUS RESEARCH.

These results fit reasonably well with Hoffman's (1984) theory of empathetic development, i.e., that children initially possess little perspective taking ability, typically experiencing personal feelings of anxiety when observing others in distress, because of their inability to distinguish others from themselves. As self/other differentiation becomes clearer, feelings of personal distress are transformed into other-orientated feelings of concern. Therefore, greater perspective taking is likely to be positively related to empathetic concern and negatively related to personal distress. Alternatively, if the self/other differentiation is not as strong, perspective taking ability will be limited and personal distress will be greater than empathetic concern.

These findings do not fit Lane and Schwartz theory quite as well. According to this theory, as already outlined, empathetic concern and personal distress for another's plight would arise only after perspective taking was established.

## 3.4. INTERCORRELATIONS OF THE SUBSCALES.

The hypothesis that intercorrelations between the subscales of this child molester sample would be similar to those in a large student sample (N=600, Davis 1983a) is largely supported. The significant negative correlation between perspective taking and personal distress (at both pre- and post-therapy testing) supports the same finding by Davis (1983a). This result is again consistent with Hoffman's theory of sequential empathetic development (1984) i.e., that greater perspective taking is likely to be positively related to empathetic concern and negatively related to personal distress. In this study, the latter proposal has been

supported, however the former, positive correlations between PT and EC, has not, with results being just short of significant levels.

The significant positive correlation between PT and FS parallels that found in Davis' study (1983a), but he attributed this finding to his large sample size. That is not a relevant factor here. It is possible that the cognitive ability involved in assuming abstract positions (such as perspective taking) may also be involved in fantasising, which is defined by Davis as "the tendency to transpose oneself into the feelings and actions of fictitious characters". This common factor could explain the correlation. However, since fantasy is the least known of the four subscales this hypothesis remains speculation.

The positive correlation between fantasy and empathetic concern is again a reiteration of Davis' finding (1983a). He states that these two share many similarities despite being distinct constructs.

To summarise then, intercorrelations of the IRI scales using data from child molesting populations show similar patterns to those found using student data (Davis, 1983a). One difference between these studies is the non significant correlation between EC and PT in the current study (as opposed to a significant correlation in Davis' study). However this is not necessarily indicative of major sample differences since non-correlational comparisons between child molesters and students on individual PT and EC subscale scores showed only one significant difference (students demonstrating more empathetic concern in one of three comparisons with molesters).

# 4. VICTIM IMPACT

## 4.1. PERSPECTIVE TAKING PERTAINING TO VICTIMS.

### 4.1.1. The similarity of offender and professional estimates.

The first question investigated the ability of molesters to accurately understand the feelings of their victims. This was achieved through comparisons of offender predictions of victim affect with professional estimations.

#### 4.1.1.1. Professionals Vs Pre-therapy Offenders.

Although professionals predicted significantly more fear, anger, abuse, powerlessness, sadness, shock, confusion, and arousal than offenders before therapy, there was no significant difference in predictions of upset, guilt, humiliation, embarrassment, disgust, betrayal, "dirty" feelings, low esteem, loneliness and "sick" emotions. Positive emotions such as ecstasy, affection, nurturing, enjoyment, excitement and fascination, and neutral emotions such as surprise and feeling ok, were not significantly different from zero (i.e., < 0.5) in each sample. Therefore in eighteen out of twenty-six cases offender estimations of victim emotions were relatively accurate. The hypothesis that offenders would predict more positive emotions than professionals was not supported. Instead they predicted very few positive emotions. It was also predicted that offenders would estimate greater victim sexual arousal than professionals but again this was not supported. Instead, the opposite was true, with professionals showing significantly more predictions of sexual arousal. These predictions were however still very few.

#### 4.1.1.2. Professionals Vs Post-therapy Offenders.

Again there were significant differences in a number of emotion categories. Professionals predicted significantly more fear, upset, humiliation, powerlessness, disgust, sadness, and arousal than offenders, and offenders predicted significantly more enjoyment and excitement than professionals. Non significant

differences were found for anger, guilt, "dirty" feelings, abuse feelings, embarrassment, betrayal, low esteem, loneliness, shock, confusion and "sick" feelings. All other positive and neutral categories were close to zero in both groups.

Again, offender predictions matched those of professionals in eighteen out of twenty-six emotion categories. However, in this post-therapy group two positive emotions, enjoyment and excitement, were predicted significantly more by offenders than by professionals.

These differences between offenders and professionals are not straightforward. A high proportion (almost 70%) of offender predictions match those of professionals indicating that these child molesters are aware of the largely negative emotions their victims experience. A surprisingly low number of positive emotions were predicted by offenders when compared to the types of positive cognitive distorting that Abel et al. (1989) demonstrate in child molesting populations. The fact that two positive emotion categories increased after therapy makes the author wonder whether social desirability had an influence on offenders. After the strong social pressures against abusing that a molester invariably encounters when caught and sentenced, it is not surprising that they would refrain from suggesting that victims enjoy the experience. This is especially so when they are in therapy supposedly to change their socially unacceptable behaviour. Also, parole is determined in part by the psychologists who see these questionnaires. Given all these pressures it is highly likely that an offender would choose to refrain from writing positive answers which are clearly not socially "correct". However, after eight weeks of daily therapy, given encouragement to state what they really think and to argue their points (to reveal distorted beliefs) without being punished, it is more likely that offenders would state those predictions of positive victim feelings, as has been shown in the cases of enjoyment and excitement. A pilot study giving the same questionnaire anonymously to a few molesters at another prison showed significantly more positive predictions of victim feelings. This reinforces the likelihood that demand characteristics at the Kia Marama Sex Offenders Unit reduced the admission of positive victim emotions.

### 4.1.2. The influence of therapy on offender estimates of victim impact.

The second question asked was whether therapy would influence offender estimations of victim impact.

Four of twenty six emotions showed significant increases after therapy. These included fear, anger, abuse, and confusion. Although this seems a small proportion, it should be remembered that eighteen of the emotions already showed similar levels to those of professionals. It seems then that therapy does have an influence, bringing child molester predictions of victim impact more in line with those of professionals. However from this study it appears that child molesters already (at the time of starting therapy) understand at least cognitively the feelings that victims of sexual abuse experience.

### 4.1.3. The influence of level of sexual contact and victim age and gender on offender estimates of victim impact.

The third question investigated whether offender predictions of victim feelings were influenced by age, gender, or level of sexual contact. Five dependant variables were used; predicted negative emotions, positive emotions, fear, anger and upset of victim.

#### 4.1.3.1. Negative emotions:

The number of predicted negative emotions was found to change significantly with age. Victims greater than twelve years being estimated to have more unpleasant feelings than the other two younger age groups. Given the types of replies received ( e.g., four year old: "doesn't know what's happening") it is possible that offenders believe that victims over the age of twelve are more aware of the social beliefs concerning sexual contact and therefore more negatively affected by the sexual advances of an adult.

#### 4.1.3.2. Positive Emotions:

There was no significant relationship found for any of the dependant variables in amounts of positive emotion predicted. It is probable that this result is due to the very small numbers of positive emotion responses in the questionnaire.

#### 4.1.3.3. Fear:

Estimations of fear changed significantly depending on age, gender, level of sexual contact and whether the estimation occurred before or after therapy. Girls were estimated to be more scared than boys. Victims aged 7-11 were predicted to be significantly more scared than those aged over twelve. Victims were predicted to be more scared of penetration than fondling, and more scared of force than penetration. Child molesters estimated more victim fear after therapy than before.

The gender difference may simply reflect social gender stereotypes. Similarly the age difference may also reflect social beliefs that younger children are more scared in general than older children. Whether this is accurate in sexual abuse cases is unclear. A comparison of these findings to those collected from a control group of non offenders may clarify whether these results are specific only to child molesters, or whether they reflect general public beliefs. Increases of fear with more intimate and more forceful abuse is predictable. In the case of force, several offenders commented that victims may be scared for their safety and even their lives. The increase in fear estimations after therapy is also predictable, as therapy aimed to educate offenders concerning the impact of their abuse on victims. Fear of course, is a common victim response, and would have been emphasised in this therapy.

#### 4.1.3.4. Anger:

Both 7-11 year olds and >12 year olds were predicted to be more angry than <6 years olds. This again may reflect the

commonly stated assumption that those under six did not know what was going on.

Therapy also had an influence, increasing the predicted anger of victims. This result would suggest that education concerning victim impact was successful in this case.

Force was believed to make victims significantly more angry than every other level of interaction. This is a reasonably predictable result given the offender's violations of the victim and distinct lack of regard for the victim's protestations.

#### 4.1.3.5. Upset:

Level of sexual contact significantly influenced offender predictions of upset in victims. Penetration was estimated to be significantly more upsetting than fondling, and force was estimated to be significantly more upsetting than penetration. This result is again relatively predictable given the greater invasions of personal privacy accompanying increased contact such as penetration, and greater fear accompanying force.

The significant gender/therapy interaction goes against expectations that predictions of upset would increase with therapy, however the numbers are extremely small in both cases. It is possible that a decrease in predictions of general upset was caused by an increase in more specific negative emotions such as fear and anger. A look at pre- and post-therapy responses does indicate that general terms before therapy were replaced by more specific emotions afterwards.

## 4.2. OFFENDER FEELINGS CONCERNING VICTIM AFFECT.

The second half of the victim impact section looked at how offenders felt when placing themselves in the position of the abuser in each scenario. It was hoped that degree of personal distress and empathetic concern could then be gauged in a situation

specifically involving sexual contact with children (as opposed to the measurement of those abilities in a general sense in the IRI.)

### 4.2.1. Individual category results.

#### Unpleasant emotions.

A total of 100% of offenders mentioned unpleasant feelings at some point in the questionnaire. On average, offenders reported feeling bad in almost half of all scenarios, indicating that offending frequently has negative affective consequences. This response rate for negative emotions is very high when it is considered that a) the answers given were free responses, b) a large number of scenarios were not answered (mean = 2/24 pre-therapy and 7/24 post-therapy) and c) bad feelings mentioned alongside good feelings are not included in this category.

#### Pleasant emotions.

The mean number of times subjects mentioned only good (as opposed to good and bad) emotions in response to a scenario was negligible before therapy and increased only slightly after therapy. The same was true for the "good and bad" category and the "good during, bad after" category. These results could have a number of explanations. They may indicate that offenders rarely feel good while offending, or they may simply reflect the reluctance of offenders to admit to what is a socially undesirable response. Given that all three categories involving good feelings increased slightly after therapy it is quite possible that offenders were more honest in post-therapy testing. This would parallel the influences of social desirability found in the first part of the victim impact questionnaire (Chapter4., section 4.1.1.2., paragraph 3). If social desirability is responsible for the low reporting of pleasant feelings then it can be assumed that in reality, offenders experience more pleasant affect than is indicated from this result.

Further investigations of subjects who are free from strong demand characteristics are necessary to investigate this point. Ideas for how this can be achieved are mentioned in section 6.

**Arousal.**

Although mean numbers of arousal responses were low (mean = 2/24 pre-therapy and 3/24 post-therapy) these figures were still larger than those for general good feelings. At face value these results could be interpreted as a sign that sexual needs are of greater importance in abuse that other emotional needs, however both means are so small that this remains purely speculation. The increase in mean number of arousal comments with therapy suggests again that social desirability may be influencing this result.

**Concern for victim.**

Numbers of subjects expressing concern for victims rose very significantly from pre- to post-therapy. Pre-therapy results indicated no expressed concern, but these results did not include subjects who answered less than 3/4 of the questionnaire.(Among these subjects there were some expressions of concern.) Even still, from this result it can be assumed that therapy has an effect on expressed concern for victim. Whether this is because of a genuine change in offender empathy or whether it simply reflects a mirroring of desirable responses learned in therapy, is unknown. It should be noted though that the answers given to the free response questions were generated entirely by each offender, showing at least a cognitive understanding of the negative consequences of sexual abuse for victims. Given this, and the fact that offenders reported high levels of unpleasant affect and showed high levels of distress in the victim impact section of therapy, it is possible that these men were genuinely concerned and distressed by the revelation of the full impact of their behaviour on victims.

**Morality**

Mean occurrences of morality statements indicating that there was nothing wrong with a scenario (i.e., morality-OK) were

negligible both before and after therapy. This result is not surprising since although the sample consisted of child molesters, these particular men had all chosen to undergo treatment. It is likely therefore, that most wanted to change, possibly indicating that at least some were aware of the negative consequences of their behaviour. (It is also possible that some subjects underwent therapy to increase chances of parole or get out of the dangerous general prison environment.)
Again demand characteristics are likely to have influenced this result;- in a therapy situation a statement that abuse is not harmful is obviously not a socially desirable opinion.

The number of molesters indicating that abuse in a scenario was "wrong" increased significantly with therapy (from 44% to 60%), however the mean responses per subject remained relatively low (mean=1.5/24, 1.8/24 questions for pre- and post-therapy respectively). Again it needs to be stated that this does not mean that offenders generally thought only 2 scenarios were immoral. It simply means that they reacted with this statement to two scenarios out of twenty four. This could be for a number of reasons (for example, in other questions they may have instead said they felt guilty, terrible or that they wouldn't do it, indicating a similar kind of disagreement with the act). Unfortunately there are no normative results to indicate where usual population levels lie.

**Guilt.**

Subjects mentioned guilt in four of twenty-four questions before therapy and five of twenty-four after therapy. This is not surprising given the fact that all subjects chose to undergo therapy, and all were under pressure to respond in a way they considered to be advantageous. It is also possible however, that subjects genuinely felt guilty for their actions, especially given the fact that subjects reported large amounts of unpleasant emotions and became personally distressed in therapy. Again it is difficult to accurately separate genuine from desirable responses in this case. Reduction of demand characteristics in future studies may clarify this point.

**Fear.**

Fear was mentioned by 56% and 60% of offenders in pre- and post-therapy testing respectively, in an average of two out of twenty-four scenarios. Frequently this fear was related to being caught in the act, or being found out, which is a realistic concern in the circumstances.

**Can't Stop.**

This statement was made infrequently by only a few offenders. Numbers were negligible both before and after therapy.

**Don't know; Wouldn't do it.**

Responses in both of these categories were relatively large before therapy but dropped significantly after therapy. (Mean=2.7, 3.2 before therapy and 0.03, 0.48 after therapy, for "don't know" and "wouldn't do it" respectively.) This drop is only partly due to reductions in denial, since many "wouldn't do it" statements were honest reflections of offender preferences. At the post-therapy stage however, subjects seemed more willing to imagine themselves in non-familiar abuse scenes.

**No answer**

This category increased significantly with therapy. During pre-therapy testing, great reluctance was shown to filling out the Victim Impact questionnaire, but the newness of the situation caused almost all subjects to oblige with therapists wishes. After eight weeks of therapy however, subjects were much more assertive, and almost a third filled out only the first question in each scenario, leaving the "How do you feel" question out altogether. It seems that offenders found it very unpleasant to have to face their feelings about being perpetrators of sexual abuse. Several said the questionnaire left them feeling lost,

depressed and upset. Therapist's were available to deal with these situations.

### 4.2.2. Summary of offender affect findings.

To conclude, the testing of offender feelings revealed that offenders were personally distressed by answering the Victim Impact Questionnaire. Unpleasant emotions and guilt were very frequent both before and after therapy. Positive emotions were very rare. Arousal and good feelings increased slightly from pre- to post-therapy testing but this may have been due to increased honesty. The "wrongness" of scenarios was reported by significantly more subjects after therapy than before, and concern for victims increased significantly from pre- to post-therapy. Fear of being caught was expressed by over half of the offenders. It seems from these results then that offenders are capable of the empathetic dimensions of personal distress and concern for victims, and that these may increase with therapy focusing on victim impact, however social desirability influences made it difficult to draw definite conclusions from these findings.

## 5. LIMITATIONS OF THE STUDY.

As all of the areas investigated in this study are relatively new and unexplored, the psychometric instruments available to test them have not yet been thoroughly refined. This problem is particularly acute in the areas of emotional awareness and cognitive distorting ,where published scales have a number of significant limitations (these are outlined earlier in the discussion). Data resulting from these scales is only as good as the scales themselves, therefore further rigorous testing of the validity and reliability of these measuring instruments is necessary.

Another limitation, pervading almost all areas of this study was the influence of demand characteristics and social desirability. It is well known that institutionalised offenders have special incentives to provide researchers with answers they think the researchers want to hear, or that will help get them released. This study was no exception. Despite efforts to reduce this

problem, some limitations of the setting and procedure were insurmountable (such as the lack of anonymity in the treatment group, and demand characteristics automatically arising from the involvement of staff psychologists in this study). These problems, like the previous ones, undermine the validity of results obtained.

Thirdly, the main sample studied, child molesters undergoing treatment, was not a representative sample of child molesters in general. These offenders were convicted (unlike the majority of child molesters), and incarcerated. Incarceration may have it's own effects on offenders, quite apart from public and legal influences leading up to imprisonment. In addition, these molesters chose to undergo therapy, making them an even more exclusive subsection of child molesters in general. However, despite the non-generalisability of these results, there is still value in the study of this population since it alone causes significant damage through recidivism.

## 6. SUGGESTIONS FOR FUTURE RESEARCH.

In addition to improving measurement devices, there needs to be a move towards the study of offenders not recruited solely from the criminal justice system. Many child molesters who are reported, are not apprehended, and many who are apprehended don't go on trial. Of those that go on trial significant numbers are not convicted. The study of these groups of potential molesters would enable a much broader investigation of molesters at large. Subjects could be recruited from those just arrested, to include people whose cases are dropped and those who are diverted to non prison programs. (It would of course be necessary to consult with therapists and prosecutors to estimate the likelihood that the offence occurred.) Subjects could also potentially be recruited from the general population by offering confidential treatment (as has been done by Abel et al. 1981). Anonymity and confidentiality could be assured using techniques similar to those of Abel and Becker (1981). This hopefully would lessen the impact of social desirability. Ideally a group could consist of subjects from all the above areas. This would provide a better picture of the extent of emotional awareness and cognitive distorting in the wider group of

child molesters, providing an indication of whether offenders in voluntary prison treatment programs are similar to offenders at large.

To measure the accuracy of offender estimates of victim impact it may be possible to gather information from the normal legal assessment interview procedure with victims, and compare this to information gathered from their abusers. This would enable an exact comparison of offender and victim perspectives, of the same abuse situation, as opposed to the more generalised methods used in this study.

If the study of offenders is confined to those in prisons or treatment institutions (this is often the most easily accessible group for study purposes) then the influence of social desirability factors and demand characteristics must be kept as low as possible. Again, confidentiality and anonymity are highly advantageous, and this may be better achieved through specified dissociation from staff involved in the parole opportunities of subjects.

Results from this study showing the positive effects of distortion therapy need to be followed up over time to see if these effects decay. If this is the case (as is hinted at in this study), then some sort of follow up therapy may prove beneficial.

The study of empathetic ability in child molesters will be most advanced by a continuation of the investigation of separate empathy dimensions. These distinct facets show independent development within individuals, and thus must be studied separately. A greater understanding of the development of empathy, and obstructions to it's development would also be of value in understanding the etiology of any deficits.

An important consequence of any deficits found in emotional awareness and empathy is the ability of offenders to respond to victim impact treatment. It may be that different treatment approaches are needed for those with different levels of awareness. More investigation of the presence and relationships between emotional awareness and empathetic ability is important in order to maximise the effectiveness of therapy. More

information is also needed concerning the etiology of deficits, and why child molesters, violent and non-violent criminals show less awareness than rapists and non-criminal controls.

The above suggestions are examples of some potential directions for future research, however the study of the phenomena outlined in this thesis is still in it's infancy, and any research would be a welcome addition to the small amount currently known.

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## APPENDIX A.

## The Interpersonal Reactivity Index.

The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by choosing the appropriate letter on the scale at the top of the page: A, B, C, D or E. When you have decided on your answer, fill in the letter in the answer space following the item. READ EACH ITEM CAREFULLY BEFORE RESPONDING. Answer as honestly and as accurately as you can. Thank you.

ANSWER SCALE

| A | B | C | D | E |
|---|---|---|---|---|
| Does Not Describe Me Well | | | | Describes Me Very Well |

ITEM

1. I daydream and fantasize, with some regularity, about things that might happen to me. _____
2. I often have tender, concerned feelings for people less fortunate than me. _____
3. I sometimes find it difficult to see things from the "other guy's" point of view. _____
4. Sometimes I don't feel very sorry for other people when they are having problems. _____
5. I really get involved with the feelings of the characters in a novel. _____
6. In emergency situations, I feel apprehensive and ill-at-ease. _____
7. I am usually objective when I watch a movie or play and I don't often get completely caught up in it. _____
8. I try to look at everybody's side of a disagreement before I make a decision. _____
9. When I see someone being taken advantage of, I feel kind of protective towards them. _____
10. I sometimes feel helpless when I am in the middle of a very emotional situation. _____
11. I sometimes try to understand my friends better by imagining how things look from their perspective. _____

## APPENDIX A. cont.

12. Becoming extremely involved in a good book or movie is somewhat rare for me. _____
13. When I see someone get hurt, I tend to remain calm. _____
14. Other people's misfortunes do not usually disturb me a great deal. _____
15. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments. _____
16. After seeing a play or movie, I have felt as though I were one of the characters. _____
17. Being in a tense emotional situation scares me. _____
18. When I see someone being treated unfairly, I sometimes don't feel very much pity for them. _____
19. I am usually pretty effective in dealing with emergencies. _____
20. I am often quite touched by things that I see happen. _____
21. I believe that there are two sides to every question and try to look at them both. _____
22. I would describe myself as a pretty soft-hearted person. _____
23. When I watch a good movie, I can very easily put myself in the place of a leading character. _____
24. I tend to lose control during emergencies. _____
25. When I'm upset at someone, I usually try to "put myself in his shoes" for a while. _____
26. When I am reading an interesting story or novel, I imagine how / would feel if the events in the story were happening to me. _____
27. When I see someone who badly needs help in an emergency, I go to pieces. _____
28. Before criticizing somebody, I try to imagine how / would feel if I were in their place. _____

## APPENDIX B.

## Description of the Sex Offender Treatment Program at Kia Marama.

This handout is given to sex offenders interested in joining the program. A therapy timetable can be found at the back of this appendix.

A) Introduction

The Kia Marama Sexual Offenders Treatment Programme was established on 2nd October 1989 at Rolleston Prison. It is a sixty bed unit which is separate from the other wings of Rolleston Prison. It is staffed by 4 Clinical Psychologists, 2 Nurse Therapists, 2 Social Workers and a Secretary.

The treatment programme runs for 32 weeks, or 7½ months, and offers intensive group therapy for those imprisoned for sexual offences against children and young people. We accept referrals from other prisons throughout New Zealand. We only accept people who volunteer to do the programme and who also understand what it involves.

Our view is that sexual offending is learned, and therefore it can be changed. This means that if you have learned to do something inappropriate, you can learn to stop doing it and meet your needs in more socially acceptable ways. In order to change your behaviour, however, you must first learn to recognize what it is you are doing, and what kinds of needs are met by your unacceptable behaviour.

The first six weeks of our programme therefore concentrates on helping you understand what you have done and why. We then help you to learn a variety of skills which help you get rid of your desires for inappropriate sex, and build your abilities to get what you want in socially acceptable ways. Finally, in the last four weeks of the programme, your will learn ways of coping with difficulties that may arise in the future.

Here is a brief outline of the programme:-

B) Assessment: 4 Weeks

During the assessment phase we aim to get an understanding of your offending history and your personal and family background. We do this in three ways:-

1) Individual interviews with a therapist
2) Questionnaires
3) Assessment of your sexual preferences, using a device which measures sexual arousal in response to slides.

This gives us the chance to get to know you, and gives you some time to learn more about the programme and make a decision about whether you want to stay.

## APPENDIX B. cont.

C) Treatment: 24 Weeks

Treatment is done in groups of 8 - 10 people, with one therapist per group throughout the programme. It divides into six parts, each lasting four weeks.

Part 1

Cognitive Restructuring: 4 Weeks

When people do something they feel bad about, they try to find reasons to justify it. Although this makes people feel better, it also encourages them to continue offending. In this group you will learn to identify the reasons or excuses you have used, and we will help you learn to look at your offences in more appropriate ways.

Part 2

i) Behavioural Reconditioning: 2 Weeks

This occupies half the time for Part 2, and teaches you ways to change your sexual preferences from children to adults.

ii) Victim Impact - Empathy: 2 Weeks

This looks at immediate and long term effects for your victims, and helps you develop empathy (feelings for others).

Part 3

i) Interpersonal Skills (2 Weeks)

In this group you will learn the skills necessary to be assertive, express your feelings and relate effectively to other adults.

ii) Relationship Skills (2 Weeks)

You will learn ways to develop and maintain rewarding relationships with adults; e.g. resolving conflict, being intimate.

Part 4

i) Social Problem Solving (2 Weeks)

In this group, you will learn how to define a problem, think of altnerative solutions, weigh up the consequences of these and how to evaluate your final solution. We will apply this model to problems each of you have experienced in your daily life.

## APPENDIX B. cont.

Part 4 (Cont'd)

ii) Anger Management or Problems with Intoxicants

In this group you will learn appropriate ways of dealing with anger or alcohol/drug use, particularly as it relates to your sexual offending.

Part 5

i) Stress Management (2 Weeks)

This group will help you learn to reduce the amount of stress in your life and deal more effectively with stress that cannot be avoided.

ii) Sex Education (2 Weeks)

This group looks at the full range of acceptable adult sexual behaviours, especially those that will improve the enjoyment of intimate relations with adults. You will also learn the full range of needs that sex can meet in your lives.

Part 6

Relapse Prevention (4 Weeks)

In this group, we will help you identify situations that could put you at a high risk for reoffending. You will learn a wide range of skills to help you cope effectively and not re-offend.

D) Re-Assessment (4 Weeks)

This will follow the same format as the initial assessment. This means we can identify the changes you have made, and evaluate the programme overall.

E) Follow-Up

A post-release programme of at least six months will be arranged with you, the therapy team and community agencies in your region.

F) Final Comments

We are aware there have been rumours about some of the procedures used in this programme. We would like to reassure you that we do not use drugs, shock treatment or any other forms of aversive therapy.

## APPENDIX B. cont.

F) Final Comments (Cont'd)

The programme is simply as outlined above. As quoted from the Kia Marama resident's magazine "Inside Wires":-

"..... come and give it a go. It's not an exam - you don't pass or fail, so what have you got to lose - absolutely nothing! You can only gain. While it is not an easy programme, it is very productive and positive".

If you are interested, or would like to discuss this programme further, apply to see the psychologist and your Divisional Officer.

We hope you decide to take this opportunity.

KIA MARAMA THERAPY TEAM

## APPENDIX B. cont.

KIA MARAMA ASSESSMENT, TREATMENT, RESEARCH

PROGRAMME

PRE -PROGRAMME
INTRODUCTION TO THE PROGRAMME

| PART NO. | WEEKS | CONTENT |
|---|---|---|
| | | ASSESSMENT |
| 0 | 1 - 4 | Assessment Process |
| | | TREATMENT |
| 1 | 5 - 8 | Cognitive Restructuring |
| 2 | 9 - 12 | a) Sexual Preference<br>b) Victim Impact/Empathy |
| 3 | 13 - 16 | a) Interpersonal Skills<br>b) Relationship Skills |
| 4 | 17 - 20 | a) Problem Solving Process<br>b) i) Anger management<br>ii) Use of intoxicants |
| 5 | 21 - 24 | a) Stress Management<br>b) Sex Education |
| 6 | 25 - 28 | Relapse Prevention<br>i) Internal Management<br>ii) External Management - Post release |
| | | ASSESSMENT |
| 7 | 29 - 32 | Reassessment - Evaluation Process |

## APPENDIX C.

## Consent form for subjects not involved in the treatment program.

I understand that the 4 questionaires I complete will be totally anonymous and that nothing I write will be held against me in any way .

This information will have absolutely no affect whatsoever on my sentence or parole , or any other legal or penal processes . It will be used for research purposes only .

I understand that I am free to decline involvement if I choose, and that this also will not be held against me in any way .

Signed _____

Date _____

## APPENDIX D.

## The questionnaires used in this study:

i.e., Level of Emotional Awareness Questionnaire
Abel and Becker Cognitions Scale, and
Victim Impact Questionnaire.

The Interpersonal Reactivity Index can be found in Appendix A.

## The Abel and Becker Cognitions Questionnaire.

Read each of the statements below carefully, and then circle the number that indicates your agreement with it.

1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree

| | Strongly Agree | | | | Strongly Disagree |
|---|---|---|---|---|---|
| 1. If a young child stares at my genitals it means the child likes what she (he) sees and is enjoying watching my genitals. | 1 | 2 | 3 | 4 | 5 |
| 2. A man (or woman) is justified in having sex with his (her) children or stepchildren, if his wife (husband) doesn't like sex. | 1 | 2 | 3 | 4 | 5 |
| 3. A child 13 or younger can make her (his) own decision as to whether she (he) wants to have sex with an adult or not. | 1 | 2 | 3 | 4 | 5 |

## APPENDIX D.cont.- ABCDQ

| | Strongly Agree | | | | Strongly Disagree |
|---|---|---|---|---|---|
| 4. A child who doesn't physically resist an adult's sexual advances really wants to have sex with the adult. | 1 | 2 | 3 | 4 | 5 |
| 5. If a 13-year-old (or younger) child flirts with an adult, it means he (she) wants to have sex with the adult. | 1 | 2 | 3 | 4 | 5 |
| 6. Sex between a 13-year-old (or younger) child and an adult causes the child no emotional problems. | 1 | 2 | 3 | 4 | 5 |
| 7. Having sex with a child is a good way for an adult to teach the child about sex. | 1 | 2 | 3 | 4 | 5 |
| 8. If I tell my young child (stepchild or close relative) what to do sexually and they do it, that means they will always do it because they really want to. | 1 | 2 | 3 | 4 | 5 |
| 9. When a young child has sex with an adult, it helps the child learn how to relate to adults in the future. | 1 | 2 | 3 | 4 | 5 |
| 10. Most children 13 (or younger) would enjoy having sex with an adult and it wouldn't harm the child in the future. | 1 | 2 | 3 | 4 | 5 |
| 11. Children don't tell others about having sex with a parent (or other adult) because they really like it and want to continue. | 1 | 2 | 3 | 4 | 5 |
| 12. Sometime in the future, our society will realize that sex between a child and an adult is all right. | 1 | 2 | 3 | 4 | 5 |
| 13. An adult can tell if having sex with a young child will emotionally damage the child in the future. | 1 | 2 | 3 | 4 | 5 |
| 14. An adult, just feeling a child's body all over without touching her (his) genitals, is not really being sexual with the child. | 1 | 2 | 3 | 4 | 5 |
| 15. I show my love and affection to a child by having sex with her (him). | 1 | 2 | 3 | 4 | 5 |
| 16. It's better to have sex with your child (or someone else's child) than to have an affair. | 1 | 2 | 3 | 4 | 5 |

## APPENDIX D.cont.- ABCDQ

| | Strongly Agree | | | | Strongly Disagree |
|---|---|---|---|---|---|
| 17. An adult fondling a young child or having the child fondle the adult will not cause the child any harm. | 1 | 2 | 3 | 4 | 5 |
| 18. A child will never have sex with an adult unless the child really wants to. | 1 | 2 | 3 | 4 | 5 |
| 19. My daughter (son) or other young child knows that I will still love her (him) even if she (he) refuses to be sexual with me. | 1 | 2 | 3 | 4 | 5 |
| 20. When a young child asks an adult about sex, it means that she (he) wants to see the adult's sex organs or have sex with the adult. | 1 | 2 | 3 | 4 | 5 |
| 21. If an adult has sex with a young child, it prevents the child from having sexual hang-ups in the future. | 1 | 2 | 3 | 4 | 5 |
| 22. When a young child walks in front of me with no or only a few clothes on, she (he) is trying to arouse me. | 1 | 2 | 3 | 4 | 5 |
| 23. My relationship with my daughter (son) or other child is strengthened by the fact that we have sex together. | 1 | 2 | 3 | 4 | 5 |
| 24. If a child has sex with an adult, the child will look back at the experience as an adult and see it as a positive experience. | 1 | 2 | 3 | 4 | 5 |
| 25. The only way I could do harm to a child when having sex with her (him) would be to use physical force to get her (him) to have sex with me. | 1 | 2 | 3 | 4 | 5 |
| 26. When children watch an adult masturbate, it helps the child learn about sex. | 1 | 2 | 3 | 4 | 5 |
| 27. An adult can know just how much sex between him (her) and a child will hurt the child later on. | 1 | 2 | 3 | 4 | 5 |
| 28. If a person is attracted to sex with children, he (she) should solve that problem themselves and not talk to professionals. | 1 | 2 | 3 | 4 | 5 |
| 29. There's no effective treatment for child molestation. | 1 | 2 | 3 | 4 | 5 |

## APPENDIX D.cont.

## The Levels of Emotional Awareness Scale:

On the top of each page are 20 situations. Please describe **what you would "feel"** in your answers. You may make your answers as brief or as long as necessary to express how you would feel. In each situation there is another person mentioned. Please indicate **how you think that other person would feel** as well.

1. A neighbour asks you to repair a piece of furniture. As the neighbour looks on, you begin hammering a nail but then miss the nail and hit your finger. How would you feel? How would the neighbour feel?

2. You are walking through the desert with a guide. You ran out of water hours ago. The nearest well is two miles away according to his map. How would you feel? How would the guide feel?

3. A loved one gives you a backrub after you return from a hard day's work. How would you feel? How would your partner feel?

4. You are running in a race with a friend whom you have trained with for some time. As you near the finish line, you twist your ankle, fall to the ground and are unable to continue. How would you feel? How would your friend feel?

## APPENDIX D.cont.- LEAS

5. You are travelling in a foreign country. A friend makes rude remarks about your own country. How would you feel? How would your friend feel?

6. As you drive over a suspension bridge you see a man standing on the other side of the guardrail, looking down at the water. How would you feel? How would the man feel?

7. Your girlfriend has been gone for several weeks but finally comes home. As she opens the door ... How would you feel? How would she feel?

8. Your boss tells you that your work has been unacceptable and needs to be improved. How would you feel? How would he feel?

9. You are standing in line at the bank. The person in front of you steps up to the window and begins a very complicated transaction. How would you feel? How would the person in front of you feel?

10. You and your wife are driving home from an evening out with friends. As you turn onto your block you see fire engines parked near your home. How would you feel? How would your wife feel?

11. You have been working hard on a project for several months. Several days after giving it in, your boss stops by to tell you that your work was excellent. How would you feel? How would your boss feel?

12. You receive an unexpected toll call from a doctor informing you that your mother has died. How would you feel? How would the doctor feel?

## APPENDIX D.cont.- LEAS

13. You tell a friend who is feeling lonely that she/he can call you whenever he/she needs to talk. One night she/he calls at 4 a.m. How would you feel? How would your friend feel?

14. Your dentist has told you that you have several holes and gives you an appointment for a return visit. How would you feel? How would the dentist feel?

15. Someone who has been critical of you in the past pays you a compliment. How would you feel? How would the other person feel?

16. Your doctor has told you to avoid fatty foods. A new colleague at work calls to say that he is going out for pizza and invites you to go along. How would you feel? How would your colleague feel?

17. You and a friend agree to invest money together to begin a new business venture. Several days later you call the friend back, only to learn that she/he has changed her/his mind. How would you feel? How would your friend feel?

18. You sell a favourite possession of your own in order to buy an expensive gift for your partner. When you give him/her the gift, he/she asks whether you sold the possession. How would you feel? How would your partner feel?

19. You fall in love with someone who is both attractive and intelligent. Although this person is not well off financially, this doesn't matter to you - your income is adequate. When you begin to discuss marriage, you

learn that she/he is actually from an extremely wealthy family. She/he did not want that known for fear that people would only be interested in him/her for his/her money. How would you feel? How would she/he feel?

20. You and your best friend are in the same line of work. There is a prize given annually to the best performance of the year. The two of you work hard to win the prize. One night the winner is announced: your friend. How would you feel? How would your friend feel?

APPENDIX D.cont.

## The Victim Impact Questionnaire.

A number of different scenes are outlined below. Each of them describes a sexual interaction between an adult and a child.

You are asked two questions about each scene. In the first question, imagine how the child would feel. Then write that down.

In the second question, write down how you would feel if you were the adult.

Please write down as many feelings as you can. Feel free to ask questions if anything is unclear. Thankyou.

1. Anna is about 10. You sometimes have intercourse with her at night when there's no-one around. She usually keeps very quiet and still.

How does Anna feel?_____

_____

_____

_____

_____

_____

How do you feel?_____

_____

_____

_____

_____

_____

_____

2. Stephen is about 8. Sometimes when he is having a bath, you go in and rub your hands all over his body, including his genitals.He wriggles around alot.

How does Stephen feel ?_____

_____

_____

_____

_____

_____

How do you feel?_____

3. Joanne is about 15. One night she is getting ready for bed when you come in and put your arms around her. She struggles but you are too strong. You throw her on the bed and have intercourse with her.

How does Joanne feel ?

How do you feel?_____

4. Gareth is about 4 . You sometimes sit him on the couch, pull back his shorts, and lick his penis. He doesn't usually say much.

How does Gareth feel ?_____

How do you feel?_____

5. Melanie is about 10. You sometimes come into her room at night, pull up her nightie, and give her oral sex. She acts as though she's asleep.

How does Melanie feel ?_____

_____

_____

_____

_____

_____

How do you feel?_____

_____

_____

_____

_____

_____

6.Richard is about 14. He often plays with you. One day when you're having a wrestle, you feel yourself getting an erection. You find yourself wanting to look at and touch Richard's penis. You try to lower his shorts, but he holds on to them and says "don't". You hold his hands behind his back and take down his shorts with your free hand. You masturbate him till he gets an erection.

How does Richard feel ?_____

_____

_____

_____

_____

_____

How do you feel?_____

_____

_____

_____

_____

_____

7. Sarah is about 4 years old. She is at home with you while her parents are away. She hears a noise in her room and gets scared,so runs to you for comfort. While she is sitting on your lap, you begin to rub your hands all over her body, including between her legs. She sits there, not moving.

How does Sarah feel ?_____

_____

_____

_____

_____

_____

How do you feel?_____

_____

_____

_____

_____

_____

8. John is about 11. You take him tramping. During the night, you remember watching him undress. You move closer to him and feel the smoothness of his back and buttocks. You have anal intercourse with him. He pretends to be asleep.

How does John feel ?_____

_____

_____

_____

_____

_____

How do you feel?_____

_____

_____

_____

_____

_____

_____

9. Matthew is about 8. He often climbs into your bed in the mornings. One morning, you start feeling him and then masturbate against him . He lies quite still.

How does Matthew feel ?_____

_____

_____

_____

_____

_____

How do you feel?_____

_____

_____

_____

_____

_____

_____

10. Sally is about 13. You sometimes come into the bathroom while she's undressed and run your hands over her body, including her breasts and between her legs. Sometimes she giggles and turns away.

How does Sally feel ?_____

_____

_____

_____

_____

_____

How do you feel?_____

_____

_____

_____

_____

_____

11. David is about 5. After you've got him out of his bath you start licking his penis. He struggles and tells you to stop, but you hold him still. You enjoy the feel of his skin.

How does David feel ?_____

How do you feel?_____

12. Amanda is about 14 . You sometimes go into her room when she is sleeping. One night you gently climb into her bed and end up having intercourse with her. She doesn't say anything and lies fairly still.

How does Amanda feel ?_____

How do you feel?_____

13. Michael is about 13. One night you go into his room and sit next to him on the bed. You put your hand in his pyjama pants, feeling his penis, then you take it in your mouth, sucking till he gets an erection.

How does Michael feel?_____

How do you feel?_____

14. Megan is about 7. You help put her to bed when her parents are out. While you are taking off her clothes you fondle her, particularly around her nipples and between her legs. She doesn't say anything.

How does Megan feel ?_____

How do you feel?_____

15. William is about 10. One afternoon, when he is alone in the bathroom after having a shower, you go in and start to feel his back and buttocks. He tries to wriggle free but you hold him, enjoying the feel of his silky smooth skin.

How does William feel

How do you feel?_____

16. Susan is about 5. When her mother is out working at night, you go in to check on her. Sometimes you climb in and feel her, sticking a finger in her vagina. She pretends to be asleep.

How does Susan feel ?_____

_____

_____

_____

_____

_____

How do you feel?_____

_____

_____

_____

_____

_____

17. Monique is about 13. You babysit for her. When she's in bed, you sometimes go in and try to arouse her by running your hands over her body and masturbating her between her legs. She moves around quite a bit.

How does Monique Feel?_____

_____

_____

_____

_____

_____

How do you feel?_____

_____

_____

_____

_____

_____

18. Robert is about 2 . He is running around with no clothes on, ready for his bath. You catch him and start fondling his body , including his genitals. He energetically wriggles around.

How does Robert feel ?_____

_____

_____

_____

_____

_____

How do you feel?_____

_____

_____

_____

_____

_____

19. Karen is about 11. One night you come into her room and fondle her. She yells and kicks but you put your hand over her mouth and hold her while running your hands over her breasts and exploring her body.

How does Karen feel ?_____

_____

_____

_____

_____

_____

How do you feel?_____

_____

_____

_____

_____

_____

20. Andrew is about 4. You are watching T.V. with him while his parents are out. He is snuggled upon the couch with you and is pressing against your penis. You enjoy the sensation of his body next to yours,and find yourself tempted to be naked with him. You quietly loosen your clothes and his and have sex with him. He asks what you're doing but doesn't try to get away.

How does Andrew feel?_____

_____

_____

_____

_____

_____

How do you feel?_____

_____

_____

_____

_____

_____

21. Lucy is about 5. You are looking after her while her parents are away. After her bath you carry her to bed and feel her body with your hands.You lower your trousers and lie against her.She tells you to stop but you keep going just long enough to have an orgasm.

How does Lucy feel ?_____

How do you feel?_____

22. Jim is about 13. You go in to check up on him, and find yourself becoming very aroused by the thought of touching him.You end up climbing into his bed and having anal intercourse with him. He asks what you're doing but doesn't yell or try to get away.

How does Jim feel ?_____

How do you feel?_____

23. Jenny is about 3. She is sitting on your lap and jiggling around alot. You find yourself getting aroused, and you start to masturbate against her.You rub your penis against her till you have an orgasm.

How does Jenny feel ?_____

_____

_____

_____

_____

_____

How do you feel?_____

_____

_____

_____

_____

_____

_____

24. Henry is about 12. When he's away on camp with you, you fondle him. Sometimes you put your hands down Henry's pants and play with his genitals, till he gets an erection.

How does Henry feel ?_____

_____

_____

_____

_____

_____

How do you feel?_____

_____

_____

_____

_____

_____

_____

## APPENDIX E.

## Scoring of the Interpersonal Reactivity Index.

Items are scored on a 5 point scale from 0 ("does not describe me well") to 4 ("describes me very well"). The scales with their associated items are as follows:

| Perspective Taking | Empathetic Concern |
|---|---|
| 3(-) | 2 |
| 8 | 4(-) |
| 11 | 9 |
| 15(-) | 14(-) |
| 21 | 18(-) |
| 25 | 20 |
| 28 | 22 |

| Fantasy | Personal Distress |
|---|---|
| 1 | 6 |
| 5 | 10 |
| 7(-) | 13(-) |
| 12(-) | 17 |
| 16 | 19(-) |
| 23 | 24 |
| 26 | 27 |

Items with a minus sign are scored in reverse , i.e.,

0 is scored as 4,

1 is scored as 3,

2 is scored as 2.

## APPENDIX G.

## Scoring chart for offender prediction of victim impact (i.e., section 1 of Victim Impact Questionnaire).

The following marking schedule indicates which emotion category belongs to which number on the score sheet.

### Negative emotion categories:

1. Horrible, terrible, awful, distressed, upset, yuckky.
1b. Low, feels bad, doesn't like it, wouldn't want it.
2. Sad, unhappy.
3. Enraged, angry, resentful, hateful, revengeful, bitter, wild.
3b. Annoyed.
4. Loathing , discusted , contemptuous..
5. Betrayed, let down, loss of confidence in you, loss of trust.
6. Powerless, helpless, hopeless.
7. Terrorised, terrified, shocked, panicked, speechless, trembling.
8. Scared, afraid, frightened, fearful.
9. Anxious, nervous, apprehensive, uncomfortable, worried, uneasy, unsafe, insecure, unsettled, concerned.
10. Abused, violated, exploited, used.
11. Humiliated, degraded.
12. Embarrassed, self conscious, bashful.
13. Guilty, ashamed, naughty, "wrong", "a bad person".
14. Dirty, unclean, soiled.
15. Lonely, isolated.
16. Low esteem, worthless.
17. Self loathing, self hate, self discust.

### Neutral emotion categories:

18. Sexually aroused, physical pleasure.
19. Surprised, speechless, dumbfounded.
20. Confused, bewildered, puzzled, uncertain.

(categories coninued on next page)

**APPENDIX G.cont.**

**Positive emotion categories:**

21. Excited.
22. Fascinated, interested, curious.
23. Ecstatic, loves it.
24. Good, happy, fun, enjoying, contented.
25. O.K.
26. Safe, warm, nurtured, loved, cared for, comforted, soothed.
27. Affectionate, loving.

If more than one example of a category is present in a scenario, only one tick is recorded.

The score sheet can be found on the following page. One sheet is used per subject, per questionaire, for recording all scenario responses. A second sheet is used to record post therapy responses. Totals for each question and for each emotion are transfered to separate "question by question", and "emotion by emotion" tally sheets, to enable comparisons of totals between groups.

# Scoring Chart – Prediction of Victim Impact.

One chart for pre-therapy and one chart for post-therapy scores (per subject.)

## Subject No. 1.– Post Therapy

### EMOTION CATEGORIES

| Question No. | No Answer | "Don't Know" | "I wouldn't do this" | "Child doesn't realise what's happening" | No emotion stated (thought or action only) | Other (specify) | NEGATIVE 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | NEUTRAL 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | POSITIVE 22 | 23 | 24 | 25 | 26 | 27 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | | | | | ✓ | | | ✓ | | | | | | | | | ✓ | | | | | | | |
| 2 | | | | | | | | | ✓ | | | | | ✓ | | | | | | | | | | | | ✓ | | | | | | | |
| 3 | | | | | | | | | ✓ | | | | ✓ | ✓ | | | | | | ✓ | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | | | | | | | | | | | | | | ✓ | | | | | | | |
| 5 | | | | | | | | | | | | | | ✓ | | | | | | ✓ | | | | | | ✓ | | | | | | | |
| 6 | | | | | | | | | ✓ | | | | | | | | | | | | | ✓ | | | | | | | | | | | |
| 7 | | | | | | | | | | | | | | | | | | | | | | | | | | ✓ | | | | | | | |
| 8 | | | | | | | | | ✓ | ✓ | | | | | | | | | | ✓ | | | | | | | | | | | | | |
| 9 | | | | | | | | | . | | | | | | | | | | | ✓ | | | | | | ✓ | | | | | | | |
| 10 | | | | | | | | | | ✓ | ✓ | | | | | | | | | | | | | | | ✓ | | | | | | | |
| 11 | | | | | | | | ✓ | | ✓ | | | | ✓ | | | | | | | | | | | | | | | | | | | |
| 12 | | | | | | | | | | | ✓ | | | | | | | | | | | ✓ | | | | ✓ | | | | | | | |
| 13 | | | | | | | | ✓ | | ✓ | | | | | | | | | | | | ✓ | | | | | | | | | | | |
| 14 | | | | | | | | . | | | | | | | | | | | | | | | | | | ✓ | | | | | | | |
| 15 | | | | | | | | | | | | | | ✓ | | | | | | | | | | | | ✓ | | | | | | | |
| 16 | | | | | | | | | | | | | | ✓ | | | | | | | | | | | | ✓ | | | | | | | |
| 17 | | | | | | | | ✓ | | | | | | ✓ | | | | | | ✓ | | | | | | | | | | | | | |
| 18 | | | | | | | | | | | | | | ✓ | | | | | | | | | | | | ✓ | | | | | | | |
| 19 | | | | | | | | ✓ | | | ✓ | | | ✓ | | | | | | | | | | | | ✓ | | | | | | | |
| 20 | | | | | | | | ✓ | | | | | | ✓ | | | | | | ✓ | | | | | | ✓ | | | | | | | |
| 21 | | | | | | | | | | | | | | ✓ | | | | | | ✓ | | | | | | ✓ | | | | | | | |
| 22 | | | | | | | | | | | | | | ✓ | | | | | | | | | | | | ✓ | | | | | | | |
| 23 | | | | | | | | | ✓ | | | | | ✓ | | | | | | | | | | | | ✓ | | | | | | | |
| | | | | | | | | / | | | | | | / | | | | | / | | | | | | | ✓ | | | | | | | |

APPENDIX G.cont.

TALS. QUESTION BY QUESTION eg 2 Negative, 1 neutral emotion (Q2) ↑

## APPENDIX H.

## List of emotion categories used in the scoring of offender predictions of victim Impact. (i.e.,Section One of the Victim Impact Questionnaire)

### Negative emotion categories:

1. Horrible, terrible, awful, distressed, upset, yuckky.
1b. Low, feels bad, doesn't like it, wouldn't want it.
2. Sad, unhappy.
3. Enraged, angry, resentful, hateful, revengeful, bitter, wild.
3b. Annoyed.
4. Loathing , discusted , contemptuous..
5. Betrayed, let down, loss of confidence in you, loss of trust.
6. Powerless, helpless, hopeless.
7. Terrorised, terrified, shocked, panicked, speechless, trembling.
8. Scared, afraid, frightened, fearful.
9. Anxious, nervous, apprehensive, uncomfortable, worried, uneasy, unsafe, insecure, unsettled, concerned.
10. Abused, violated, exploited, used.
11. Humiliated, degraded.
12. Embarrassed, self conscious, bashful.
13. Guilty, ashamed, naughty, "wrong", "a bad person".
14. Dirty, unclean, soiled.
15. Lonely, isolated.
16. Low esteem, worthless.
17. Self loathing, self hate, self discust.

### Neutral emotion categories:

18. Sexually aroused, physical pleasure.
19. Surprised, speechless, dumbfounded.
20. Confused, bewildered, puzzled, uncertain.

(categories coninued on next page)

APPENDIX H.cont.

**Positive emotion categories:**

21. Excited.
22. Fascinated, interested, curious.
23. Ecstatic, loves it.
24. Good, happy, fun, enjoying, contented.
25. O.K.
26. Safe, warm, nurtured, loved, cared for, comforted, soothed.
27. Affectionate, loving.

## APPENDIX I.

## Scoring chart for the second section of the Victim Impact Questionnaire,i.e., offender feelings concerning abuse scenarios.

Note that the following sections are mutually exclusive:

Good,
Good and Bad,
Good during, bad afterwards.

If fear and/or guilt are present, a tick is also placed in the bad (i.e., unpleasant) category.

If more than one example of a category is present in a scenario, only one tick is recorded.

The score sheet can be found on the following page. One sheet is used per subject, per questionaire, for recording all scenario responses. A second sheet is used to record post therapy responses. Totals for each question and for each emotion are transfered to separate "question by question", and "emotion by emotion" tally sheets, to enable comparisons of totals between groups.

Subject No: ___ Pre Therapy ☐ Post Therapy ☐ (Tick correct box)

Scoring Chart – Offender Feelings (Victim Impact Questionnaire.)

One chart for each subjects pre therapy responses and one for each subjects post therapy responses.

| Question Number | Other; specify: emotions or comments | | Guilt | Arousal | Fear | Good feelings | Good and bad | Good during after bad | Neutral | Bad (ie unpleasant) | concerned for victim | Morality - OK | Morality - Not OK | Can't stop | Wouldn't do it. | Don't know | No Answer | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | | | | | | | | | | | | |
| 7 | | | | | | | | | | | | | | | | | | | | | | | | |
| 8 | | | | | | | | | | | | | | | | | | | | | | | | |
| 9 | | | | | | | | | | | | | | | | | | | | | | | | |
| 10 | | | | | | | | | | | | | | | | | | | | | | | | |
| 11 | | | | | | | | | | | | | | | | | | | | | | | | |
| 12 | | | | | | | | | | | | | | | | | | | | | | | | |
| 13 | | | | | | | | | | | | | | | | | | | | | | | | |
| 14 | | | | | | | | | | | | | | | | | | | | | | | | |
| 15 | | | | | | | | | | | | | | | | | | | | | | | | |
| 16 | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 | | | | | | | | | | | | | | | | | | | | | | | | |
| 18 | | | | | | | | | | | | | | | | | | | | | | | | |
| 19 | | | | | | | | | | | | | | | | | | | | | | | | |
| 20 | | | | | | | | | | | | | | | | | | | | | | | | |
| 21 | | | | | | | | | | | | | | | | | | | | | | | | |
| 22 | | | | | | | | | | | | | | | | | | | | | | | | |
| 23 | | | | | | | | | | | | | | | | | | | | | | | | |
| 24 | | | | | | | | | | | | | | | | | | | | | | | | |

**APPENDIX I.cont.**

→ Totals for each question → (Question totals over all subjects are tallied on a separate sheet)

## APPENDIX J.

## Graphs showing the frequency distributions of cognitive distortion scores.

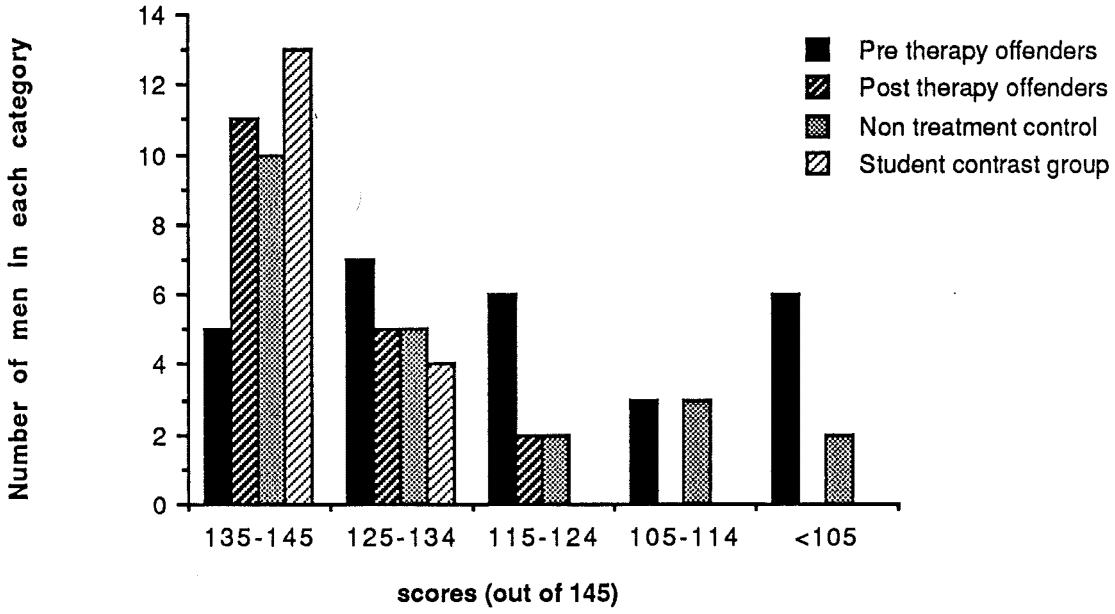
Graph one shows the frequency distribution of scores for the following groups:

A. Child molesters in therapy;
   A1 : pre-therapy; subjects tested prior to treatment,
   A2 : post-therapy; the same subjects tested eight weeks later after cognitive distortion therapy. (N=27 pre, 18 post)
B. Child molesters not in treatment. (N=22, results courtesy of R.Morgan)
C. Male Student Contrast. (N=17)

Graph two shows the differences in group A scores from pre- to post-therapy. Note that no offender scored lower than 115 after therapy, indicating a significant decrease in cognitive distortions after therapy.

See following page for graphs

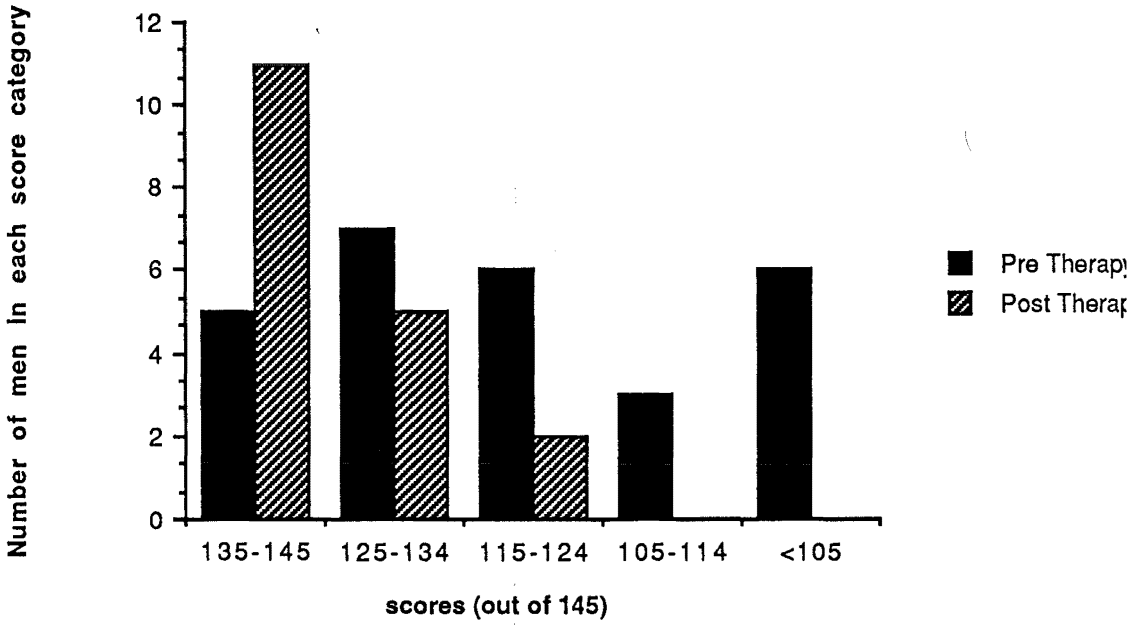
**Graph one: The frequency distribution of scores for offenders in treatment , offenders not in treatment and the student contrast group.**




(See over for graph 2)

## APPENDIX J.cont.

**Graph two: The frequency distribution of scores for offenders in treatment, both before therapy and after therapy**



## APPENDIX K.

## The Abel and Becker Cognitions Scale- Question means.

Detailed below are the average scores for each question of the Abel and Becker Cognitions Scale.

Groups are:-

A. Treatment group child molesters (both prior to therapy and after cognitive distortion therapy. (N=27 pre,18 post)
B. Non-treatment child molesters. (N=18)
C. Male Student contrast. (N=17)

Questions are rated as follows:-

1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree

| Questions. | Mean Scores. | | | |
|---|---|---|---|---|
| | A. Treatment: | | B. Non-Treat: | C. Student Contr: |
| | A(pre): | A(post): | B: | C: |
| 1. If a young child stares at my genitals it means the child likes what she (he) sees and is enjoying watching my genitals. | 4.03 | 4.81 | 3.94 | 4.41 |
| 2. A man (or woman) is justified in having sex with his (her ) children or step-children, if his wife(husband) doesn't like sex. | 4.41 | 4.96 | 4.78 | 5.00 |

**Appendix K continued.**

| | | | | |
|---|---|---|---|---|
| 3. A child 13 or younger can make her (his) own decision as to whether she (he) wants to have sex with an adult or not. | 3.92 | 4.59 | 4.44 | 4.41 |
| 4. A child who doesn't physically resist an adult's sexual advances really wants to have sex with the adult. | 4.07 | 4.96 | 4.44 | 4.94 |
| 5. If a 13-year-old (or younger) flirts with an adult it means he (she) wants to have sex with the adult | 3.74 | 4.81 | 4.28 | 4.94 |
| 6. Sex between a 13-year-old (or younger) child and an adult causes the child no emotional problems | 4.37 | 5.00 | 4.44 | 4.82 |
| 7. Having sex with a child is a good way for an adult to teach the child about sex | 4.37 | 5.00 | 4.78 | 4.82 |
| 8. If I tell my child (stepchild) or close relative) what to do sexually and they do it, that means they will always do it because they really want to. | 3.80 | 4.89 | 4.33 | 4.94 |
| 9. When a young child has sex with an adult, it helps the child learn how to relate to adults in the future. | 4.44 | 4.89 | 4.44 | 4.88 |

**Appendix K continued.**

| | | | | |
|---|---|---|---|---|
| 10.Most children 13 (or younger) would enjoy having sex with an adult and it wouldn't harm the child in the future. | 4.19 | 4.93 | 4.11 | 4.88 |
| 11.Children don't tell others about having sex with a parent (or other adult) because they really like it and want it to continue. | 4.22 | 4.96 | 4.56 | 5.00 |
| 12.Sometime in the future, our society will realise that sex between a child and an adult is all right. | 4.44 | 4.78 | 4.61 | 4.47 |
| 13.An adult can tell if having sex with a young child child will emotionally damage the child in the future. | 2.74 | 2.45 | 2.50 | 4.76 |
| 14.An adult, just feeling a child's body all over without touching her (his) genitals, is not really being sexual with the child. | 3.63 | 4.07 | 2.50 | 4.65 |
| 15.I show my love and affection to a child by having sex with her (him) | 4.44 | 4.81 | 4.61 | 4.94 |
| 16.It's better to have sex with your child (or someone else's child) than to have an affair. | 4.70 | 4.88 | 4.83 | 5.00 |

**Appendix K continued.**

| | | | | |
|---|---|---|---|---|
| 17.An adult fondling a young child or having the child fondle the adult will not cause the child any harm. | 4.19 | 4.41 | 4.59 | 4.76 |
| 18.A child will never have sex with an adult unless the child really wants to. | 4.11 | 4.81 | 4.47 | 5.00 |
| 19.My daughter (son) or other young child knows that I will still love her (him) even if she (he) refuses to be sexual with me. | 2.15 | 3.60 | | 4.00 |
| 20.When a young child asks an adult about sex, it means that she (he) wants to see the adult's sex organs or have sex with the adult. | 4.33 | 4.85 | 4.44 | 5.00 |
| 21.If an adult has sex with a young child, it prevents the child from having sexual hang-ups in the future. | 4.63 | 4.93 | 4.45 | 5.00 |
| 22.When a young child walks in front of me with no or only a few clothes on, she (he) is trying to arouse me. | 4.22 | 4.74 | 4.56 | 5.00 |
| 23.My relationship with my daughter (son) or other child is strengthened by the fact that we have sex together. | 4.48 | 4.92 | 4.78 | 4.94 |
| 24.If a child has sex with an adult, the child will look back at the experience as an adult and see it as a positive experience. | 4.52 | 4.74 | 4.56 | 5.00 |

**Appendix K continued.**

| | | | | |
|---|---|---|---|---|
| 25.The only way I could do harm to a child when having sex with her (him) would be to use physical force to get her (him) to have sex with me. | 4.07 | 4.74 | 4.44 | 5.00 |
| 26.When children watch an adult masturbate it helps the child learn about sex. | 4.15 | 4.74 | 4.45 | 4.71 |
| 27. An adult can know just how much sex between him (her) and the child will hurt the child later on. | 3.07 | 4.30 | 3.43 | 4.94 |
| 28.If a person is attracted to sex with children, he (she) should solve that problem themselves and not talk to professionals. | 4.45 | 4.70 | 4.33 | 4.94 |
| 29. There's no effective treatment for child molestation. | 4.30 | 4.70 | 3.20 | 4.24 |

The above individual question means were calculated to establish the strength of various distortions in the four sample groups. The results indicated that those most strongly distorted attitudes and beliefs (i.e., scoring less than four) were questions 1, 3, 5, 8, 13, 14, 19 and 27. The lowest scores (i.e., most distorted) were found in questions 13, 14 and 19. However, these questions were also judged to be the most ambiguous in meaning (Morgan, 1991), making it difficult to determine whether scores were due to greater distortion or simple misunderstanding. Given that one pilot study of female psychology students (by the author) also revealed large distortions on these most ambiguous questions, it is entirely possible that ambiguity of wording influenced these results.

## Appendix L.

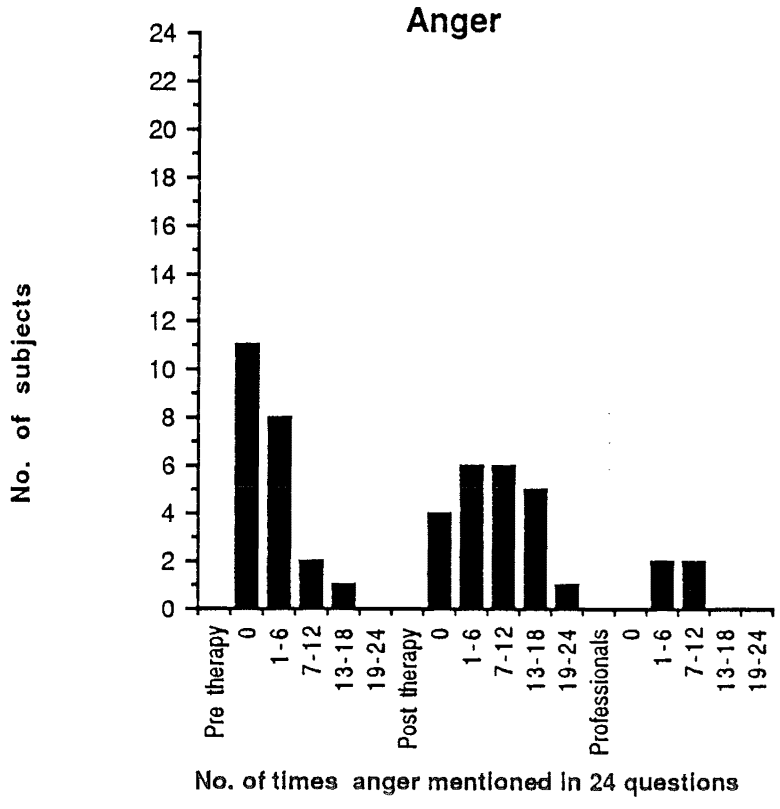
## Graphs showing the frequency distribution of offender and professional predictions of the various categories of victim emotions.

The following graphs show the frequency distribution of responses for each emotion. Each graph indicates the number of occurrences of an emotion in 24 questions by

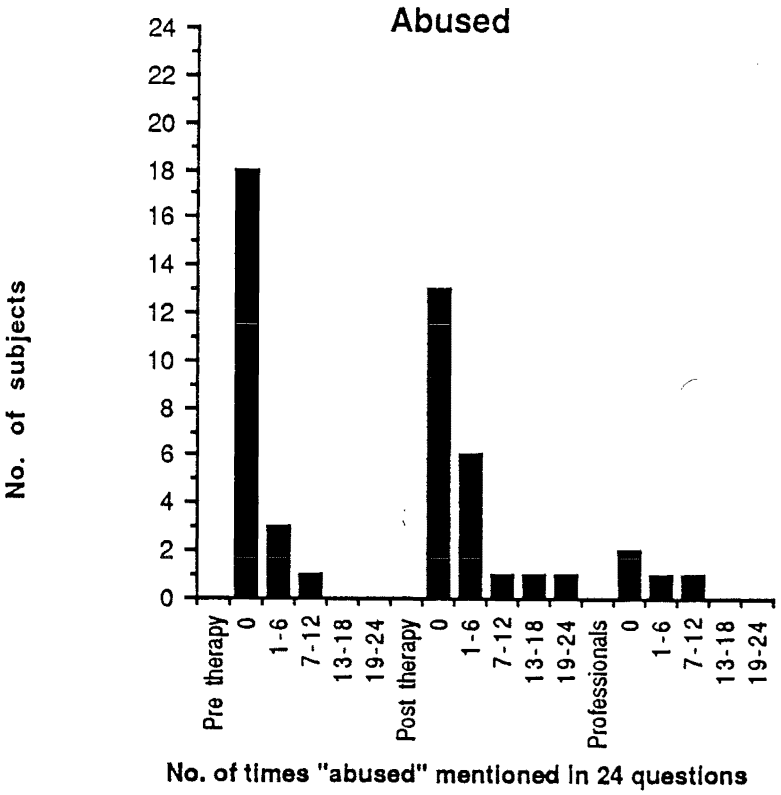
a) offenders before therapy (N=26)
b) offenders after therapy (N=20)
c) professionals (N=5).

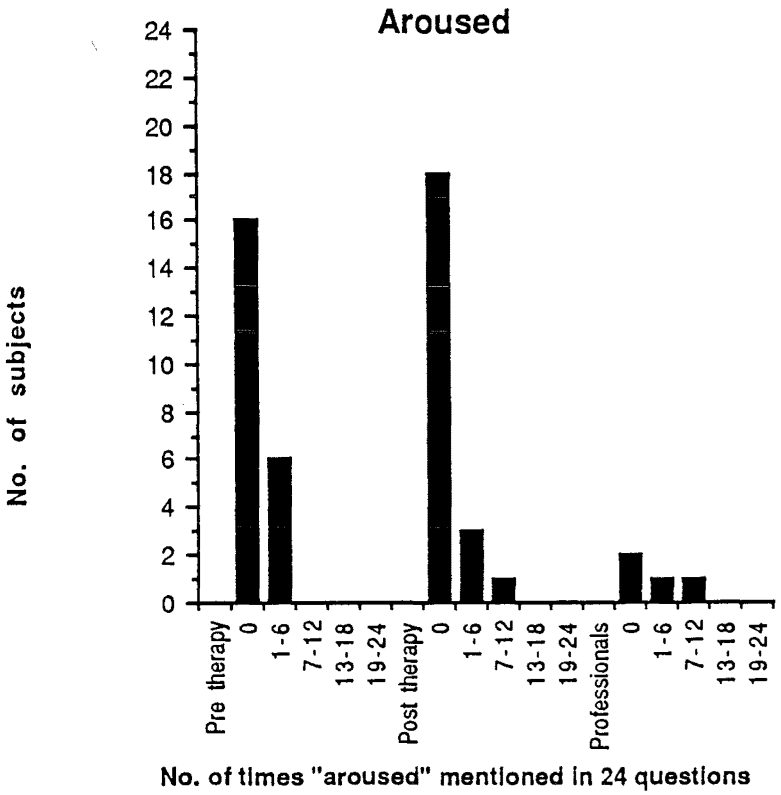
Note that distribution is more important than hight comparisons on these graphs. Professionals have less hight simply because there are less of them in the sample. The significance of differences between groups in frequency of each emotion, is detailed in Chp. 3, sections 4.1.1., 4.1.2., and 4.2.2.

### FREQUENCY DISTRIBUTION GRAPHS FOR EACH EMOTION:



Appendix L. cont.



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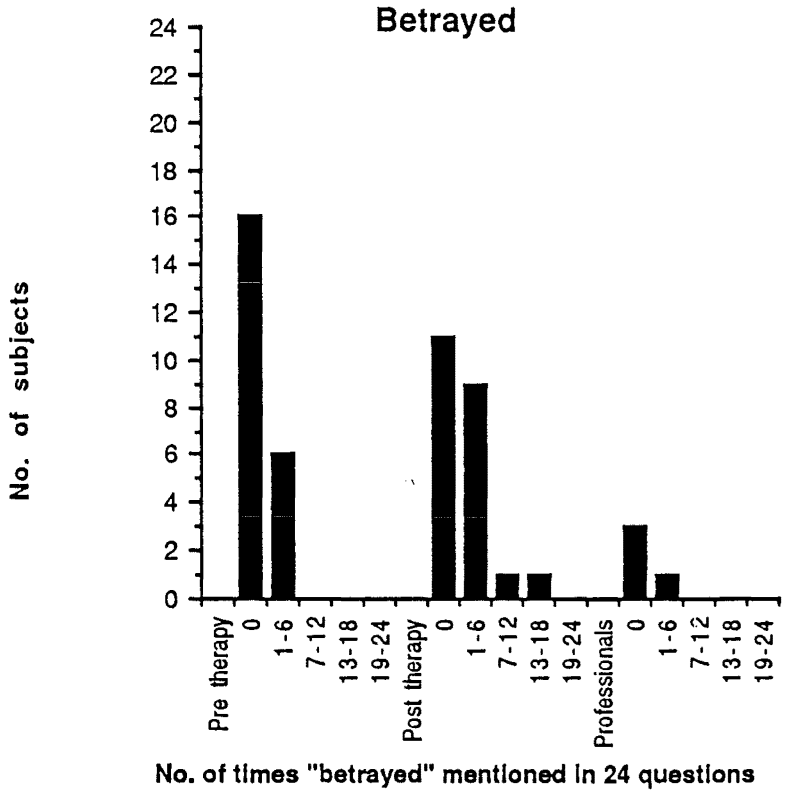


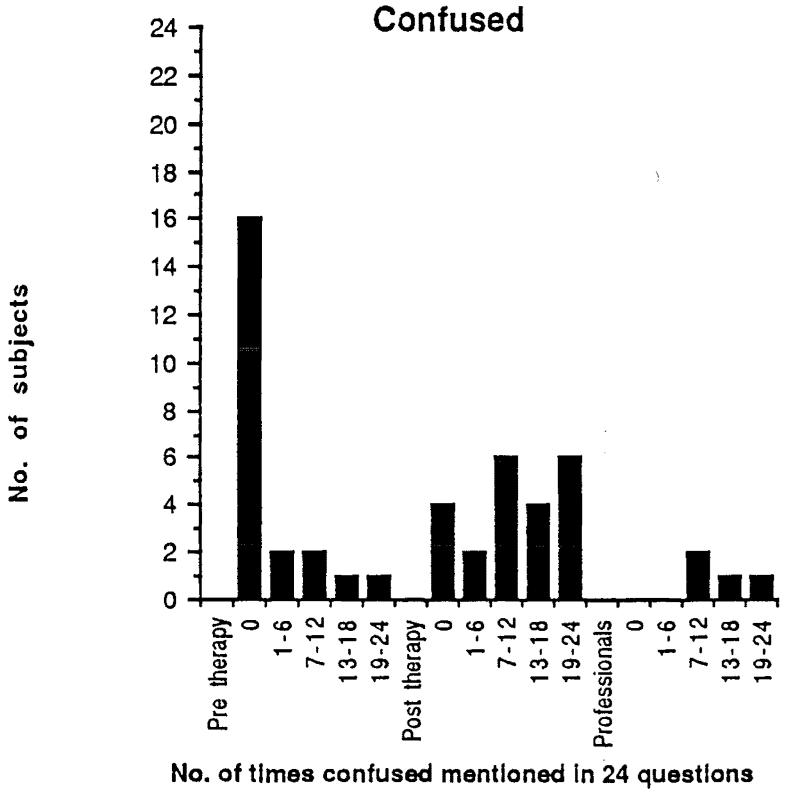

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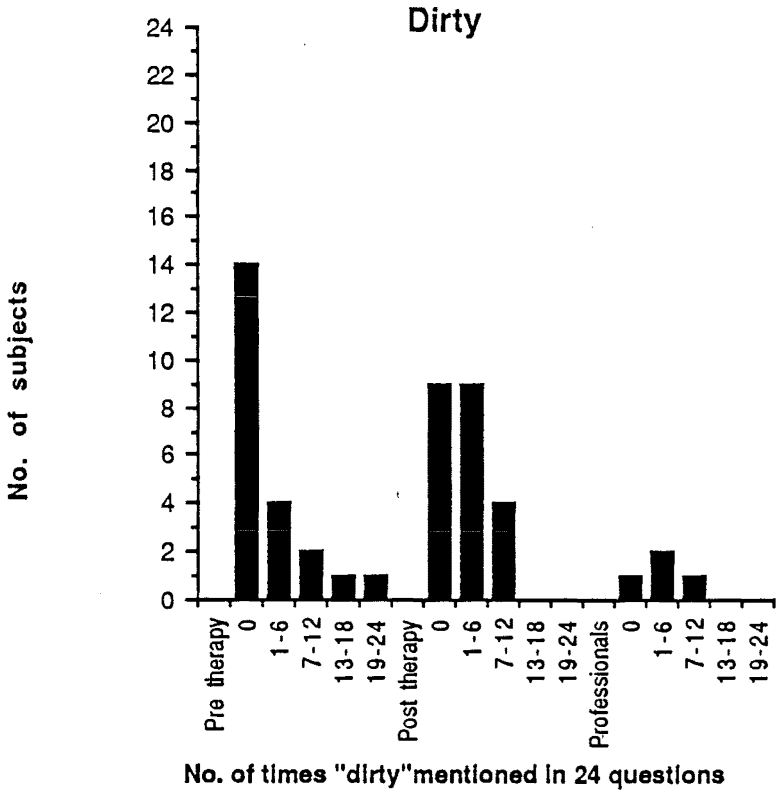


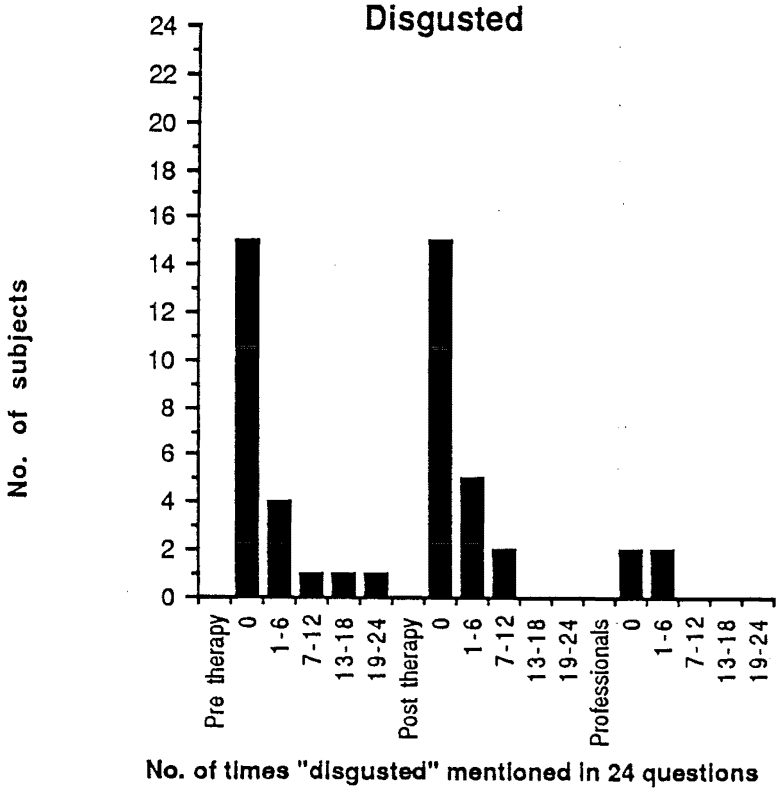

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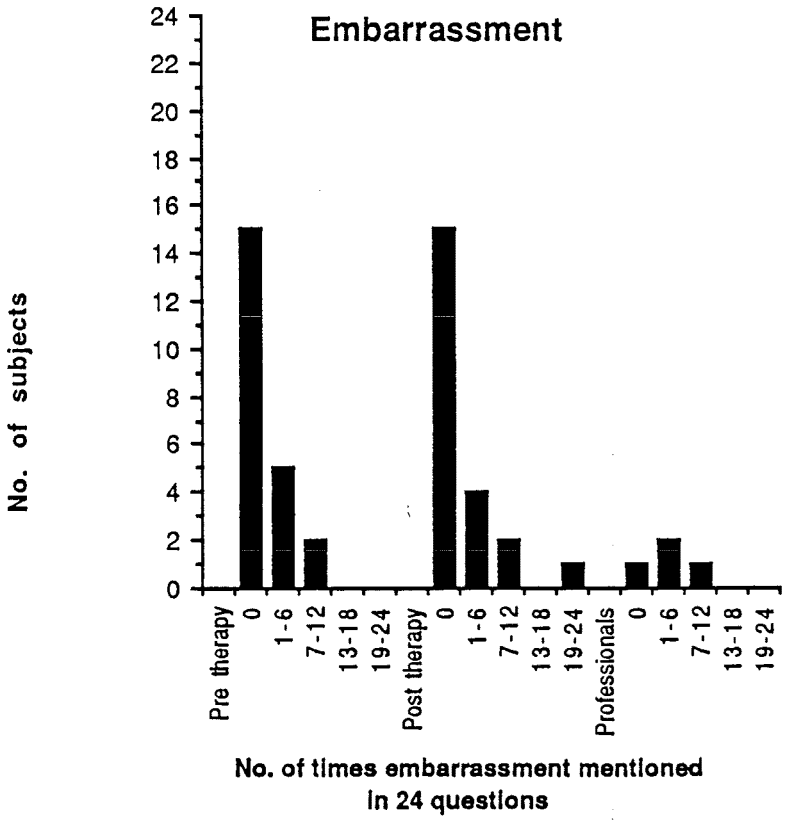


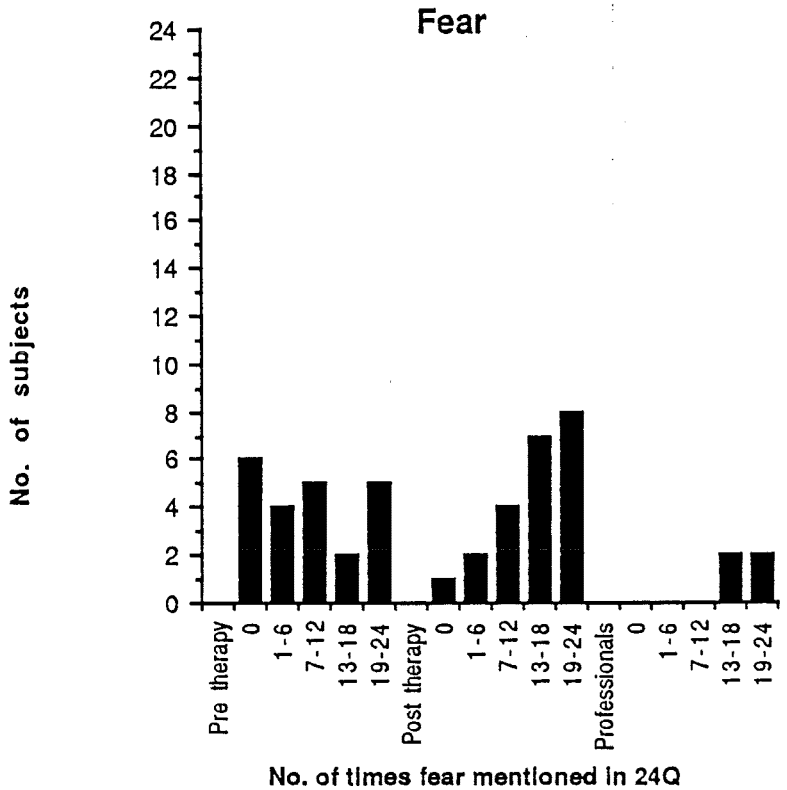

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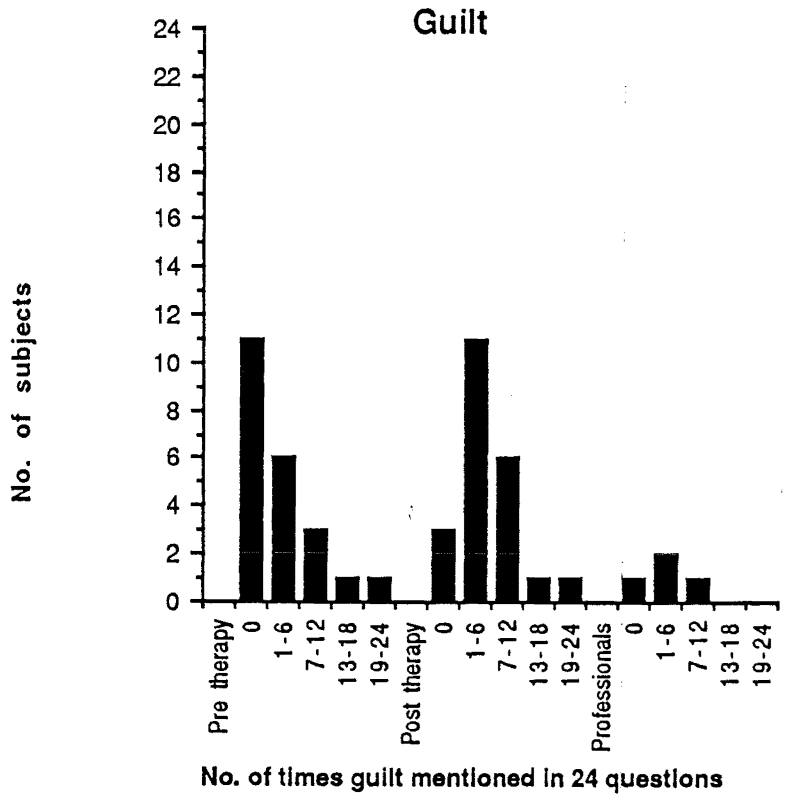


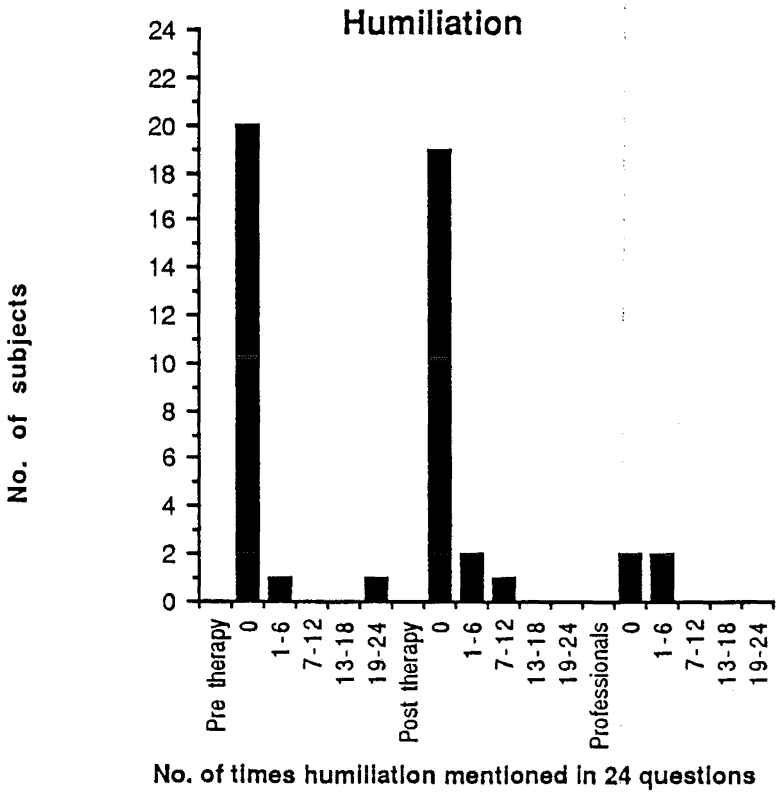

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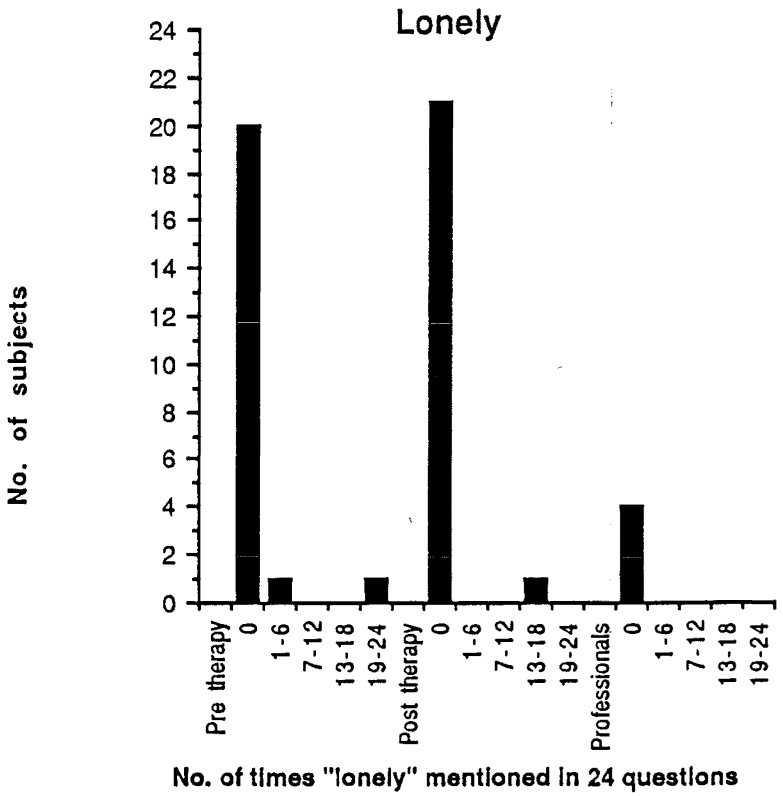


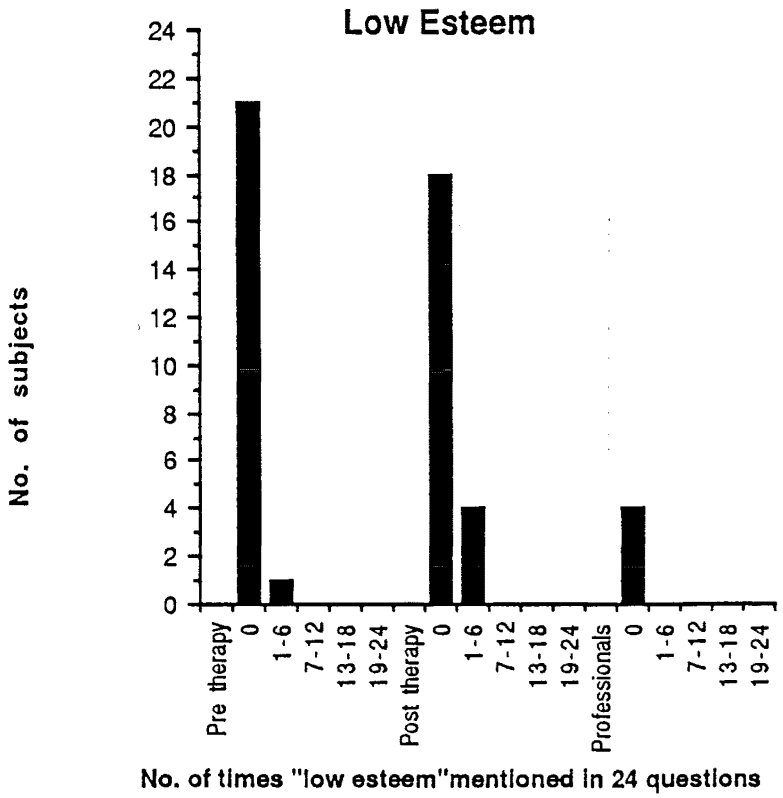

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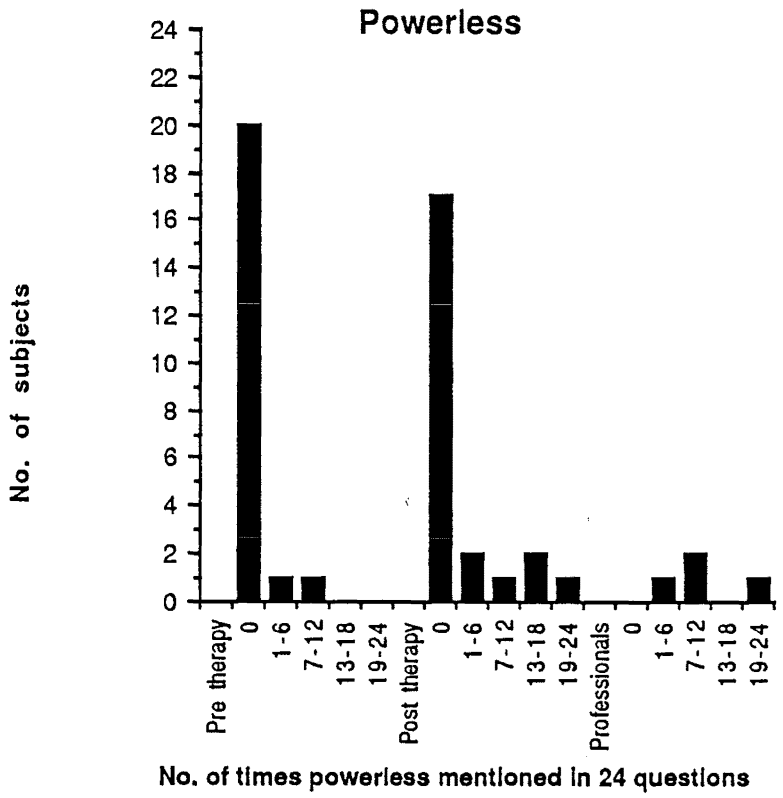


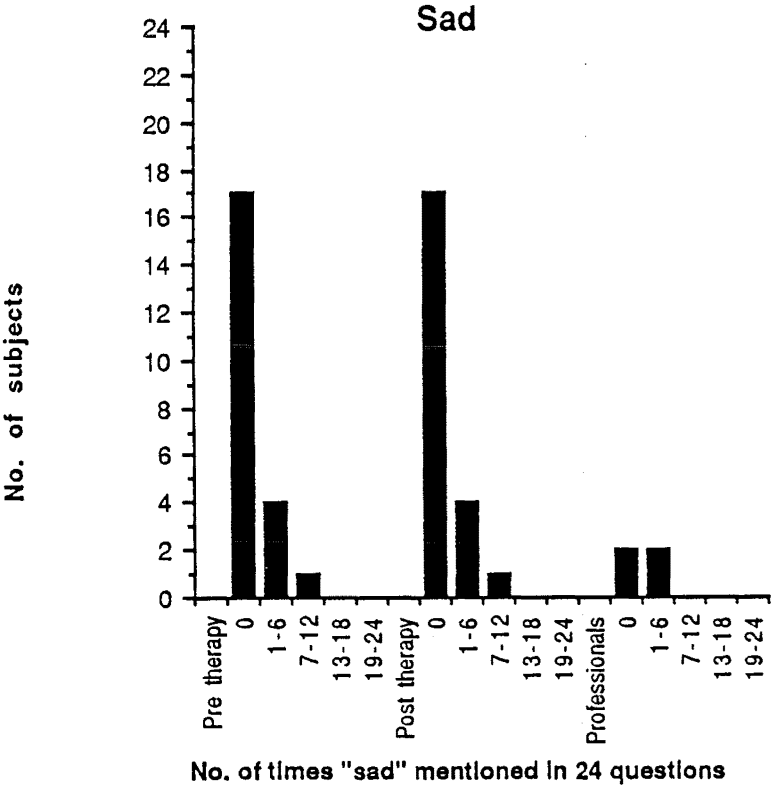

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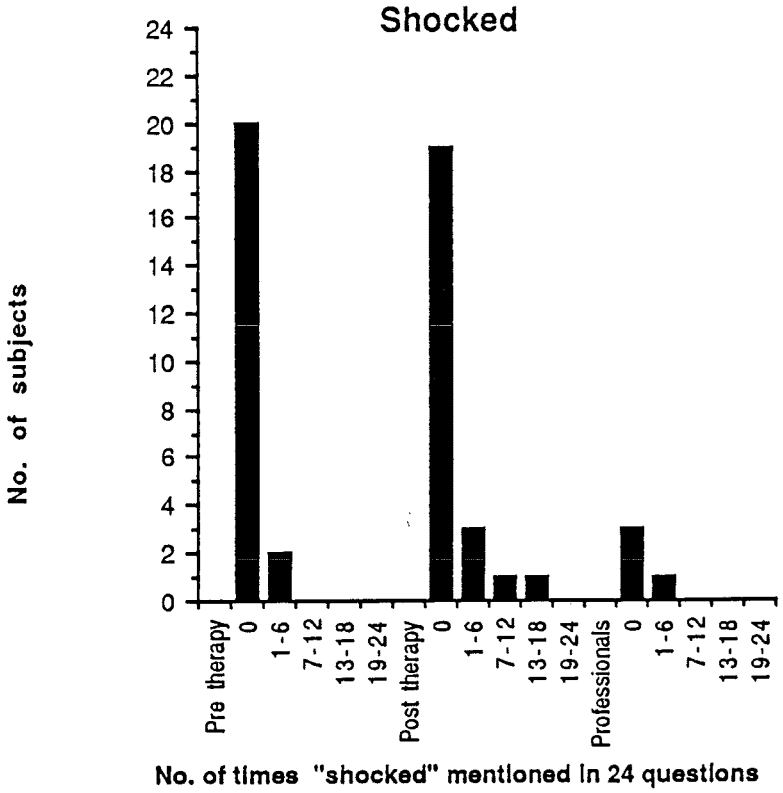


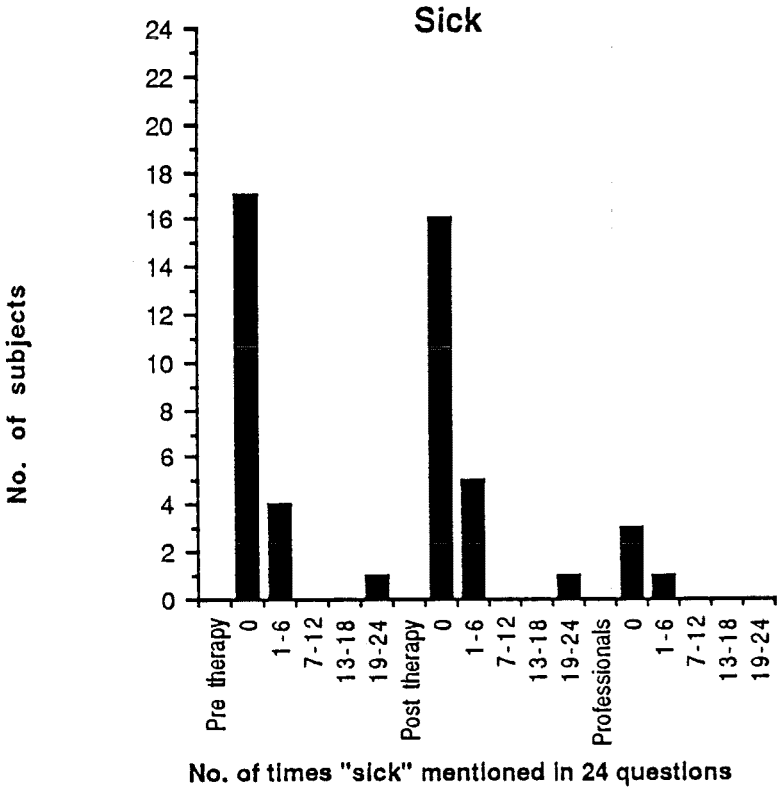

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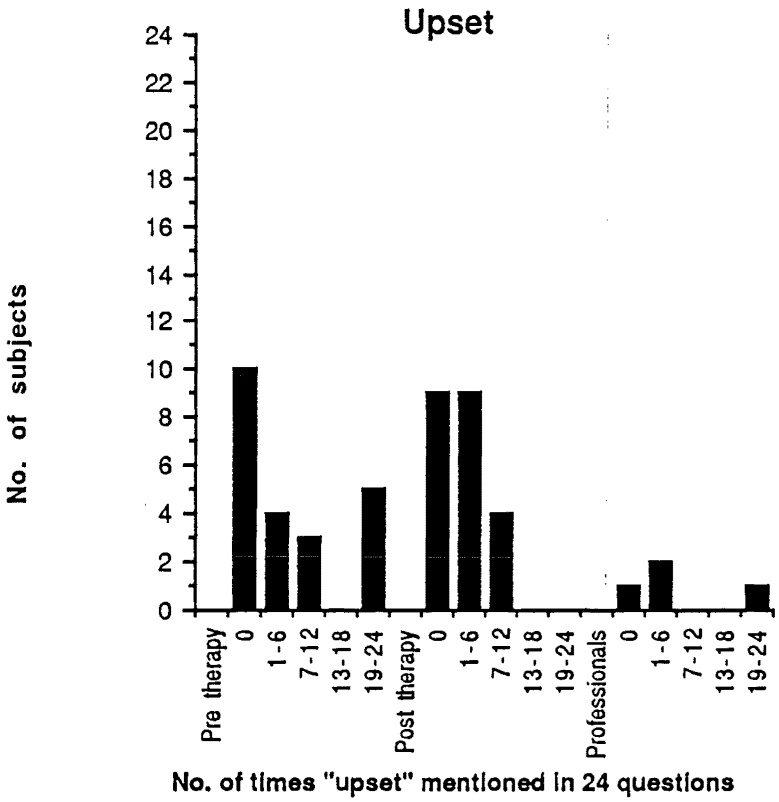
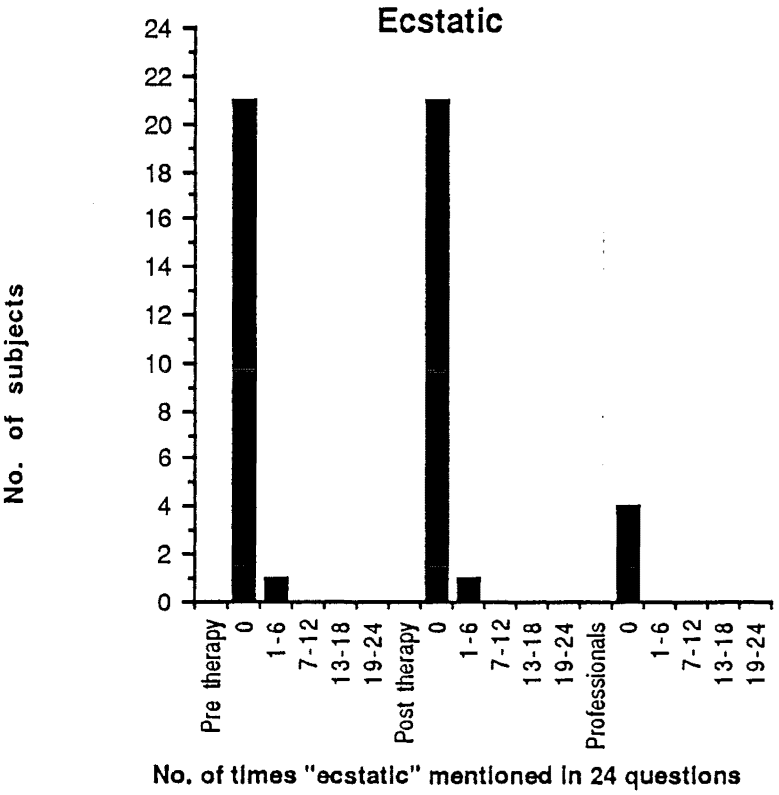
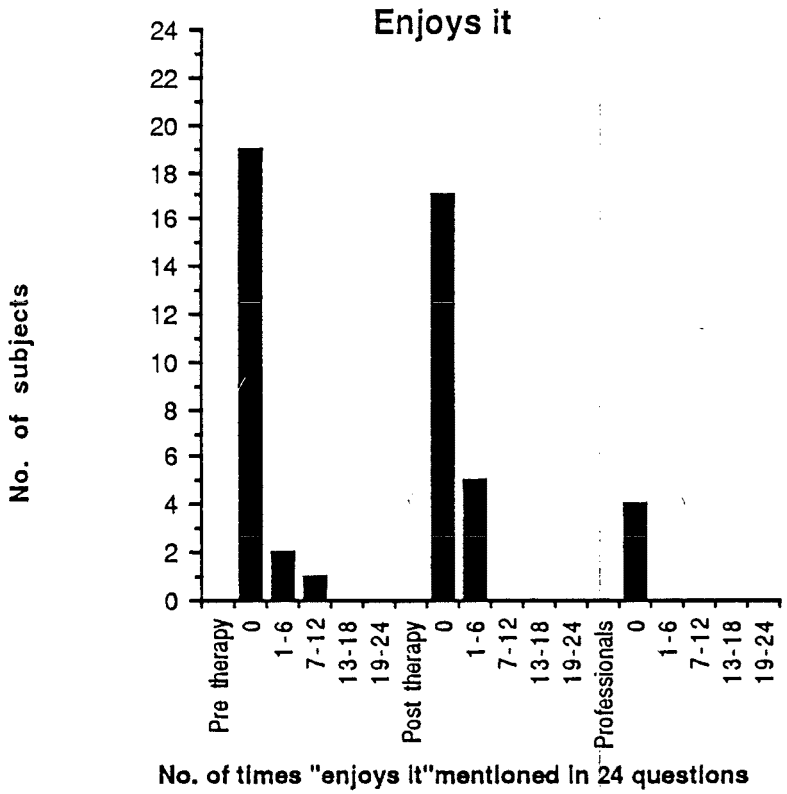
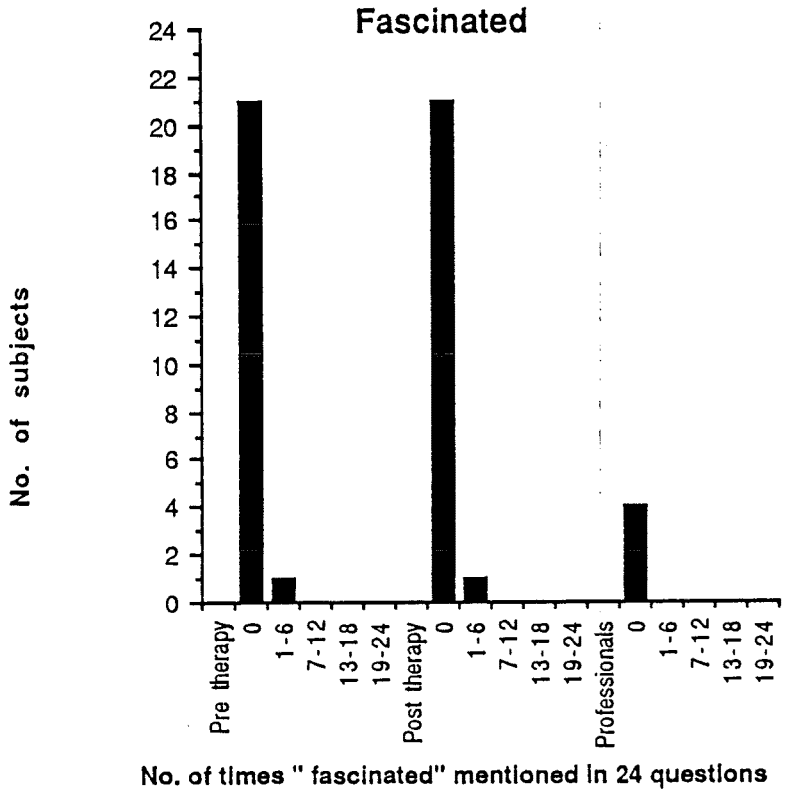


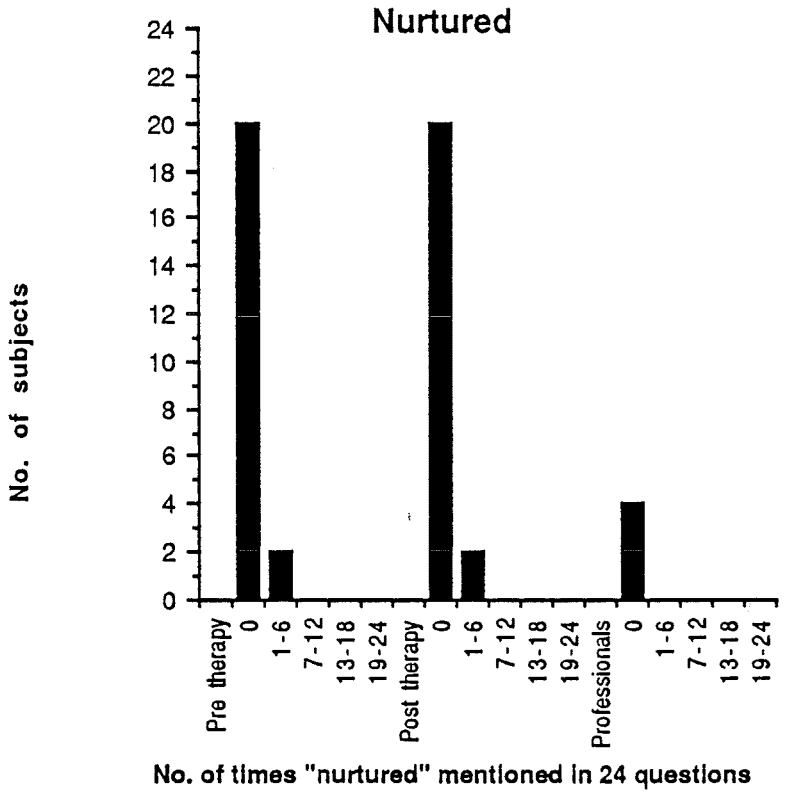



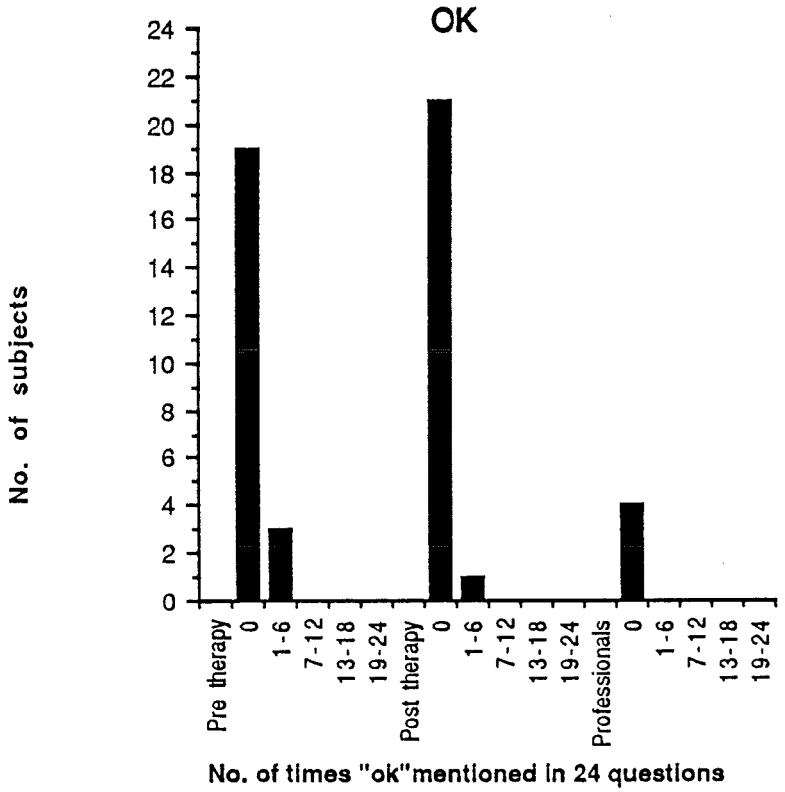
Appendix L. cont.



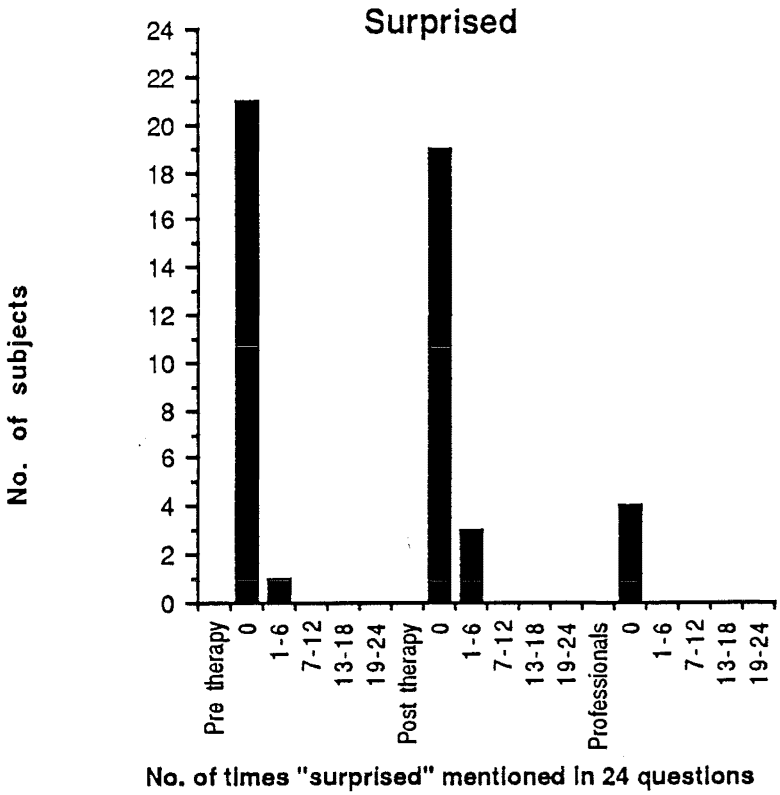



Appendix L. cont.



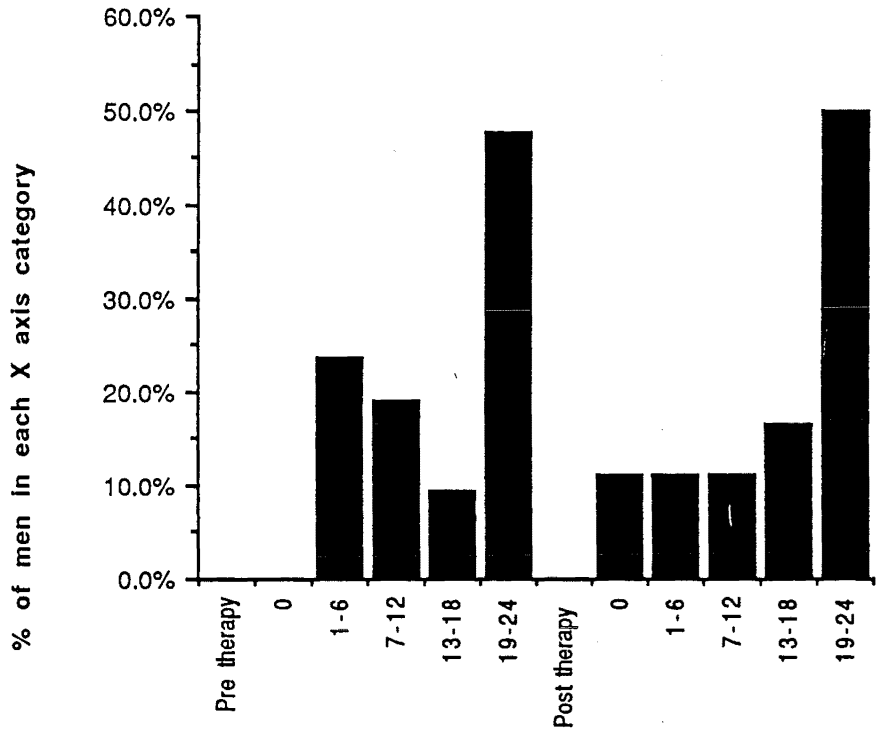
Appendix L. cont.



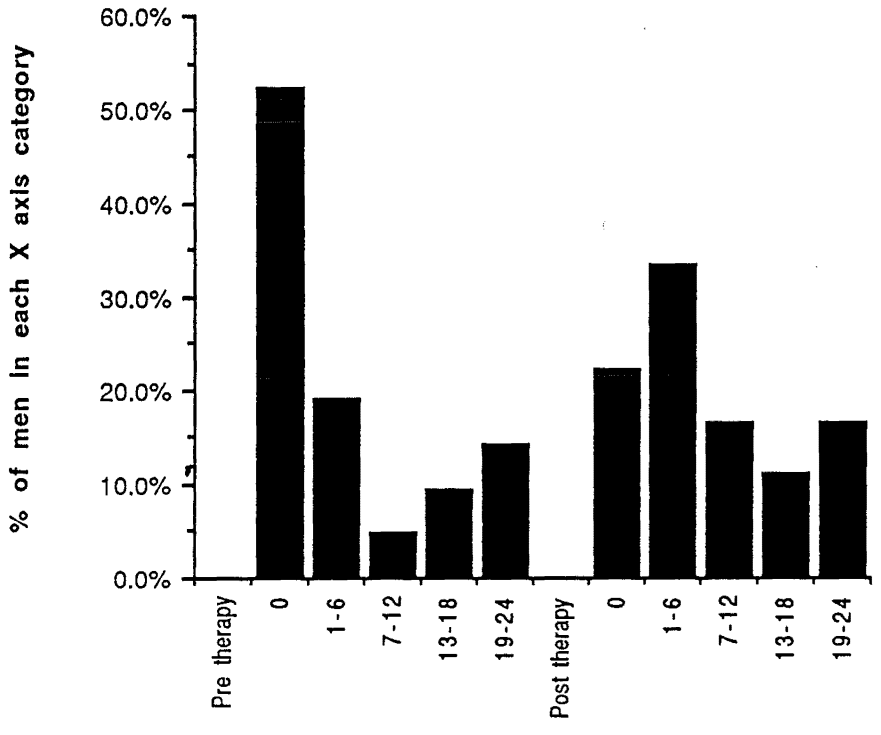
## Appendix M.

## Graphs showing the frequency distribution of offender reactions to victim impact scenarios.

The following graphs outline offender responses both before and after therapy for each of the 13 response categories.

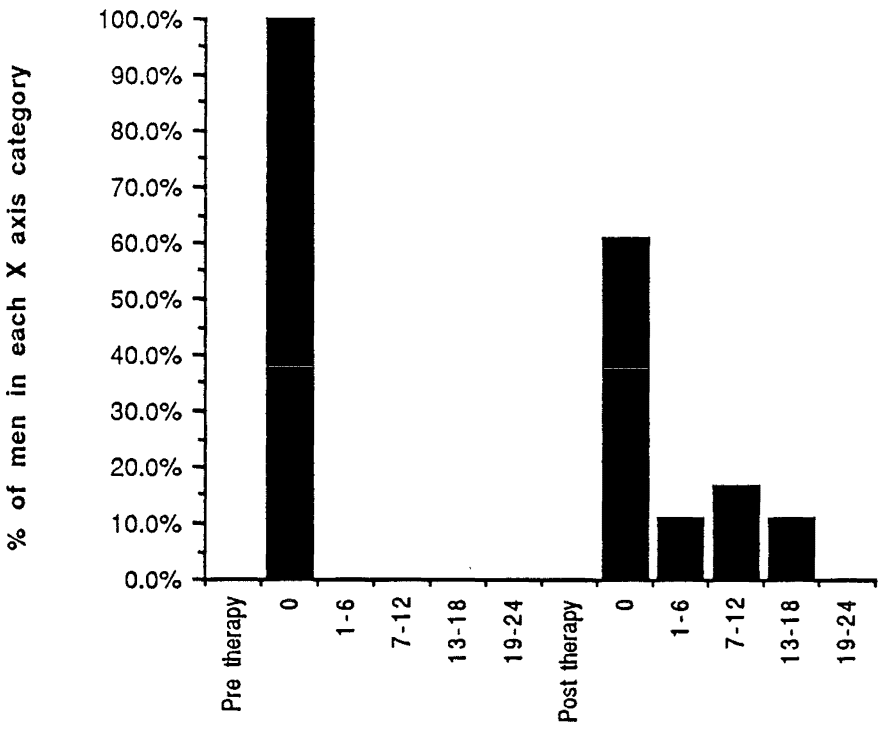



**No. of times UNPLEASANT EMOTIONS mentioned in 24 responses**

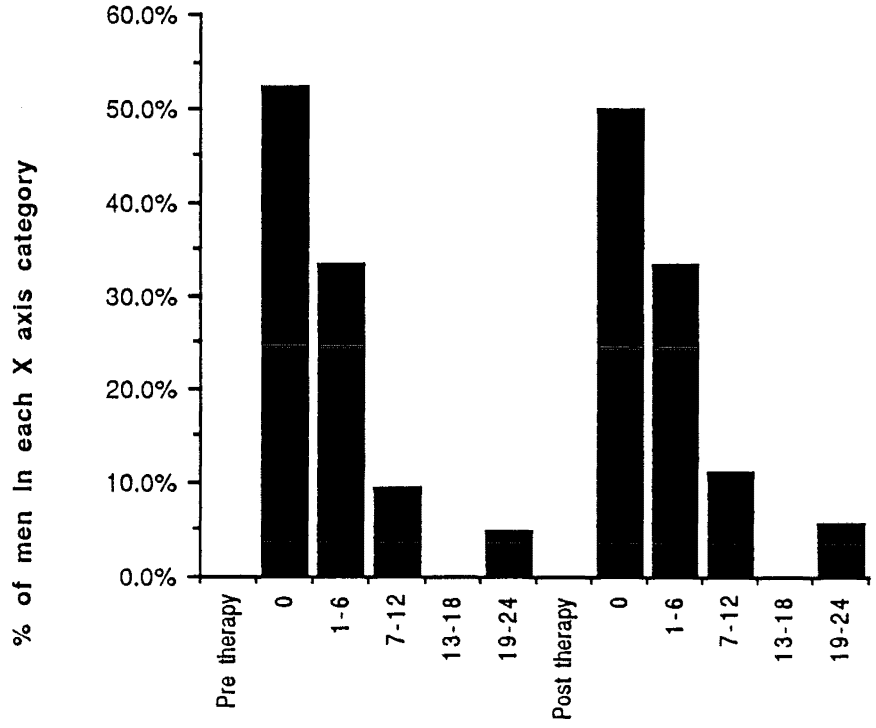



**Number of times GUILT mentioned in 24 responses**

## Appendix M. cont.

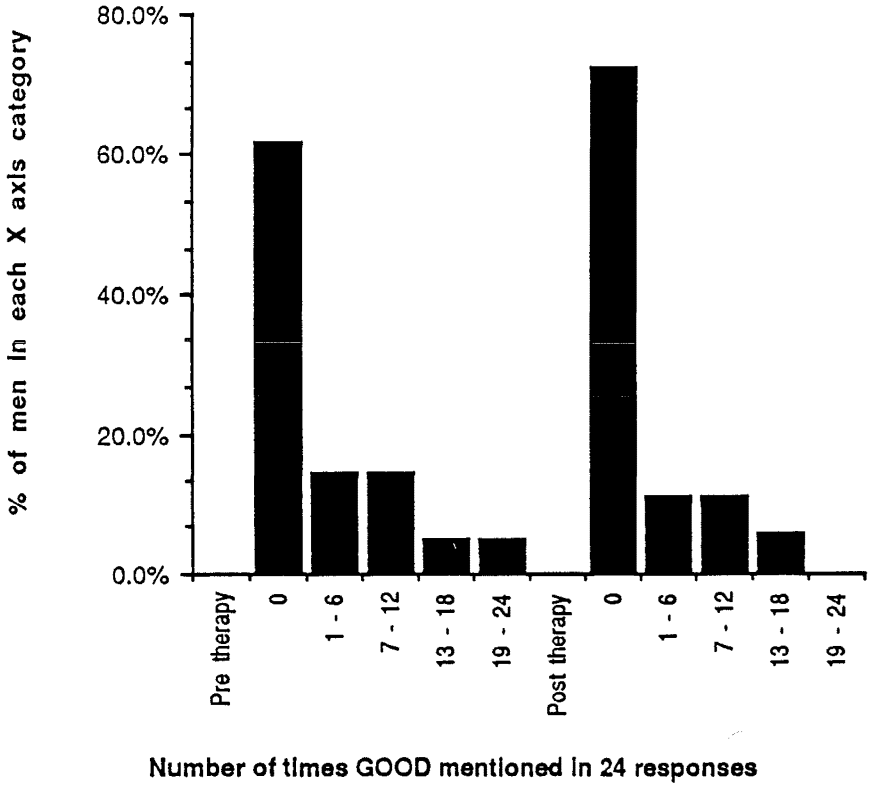



Number of times CONCERN mentioned in 24 responses

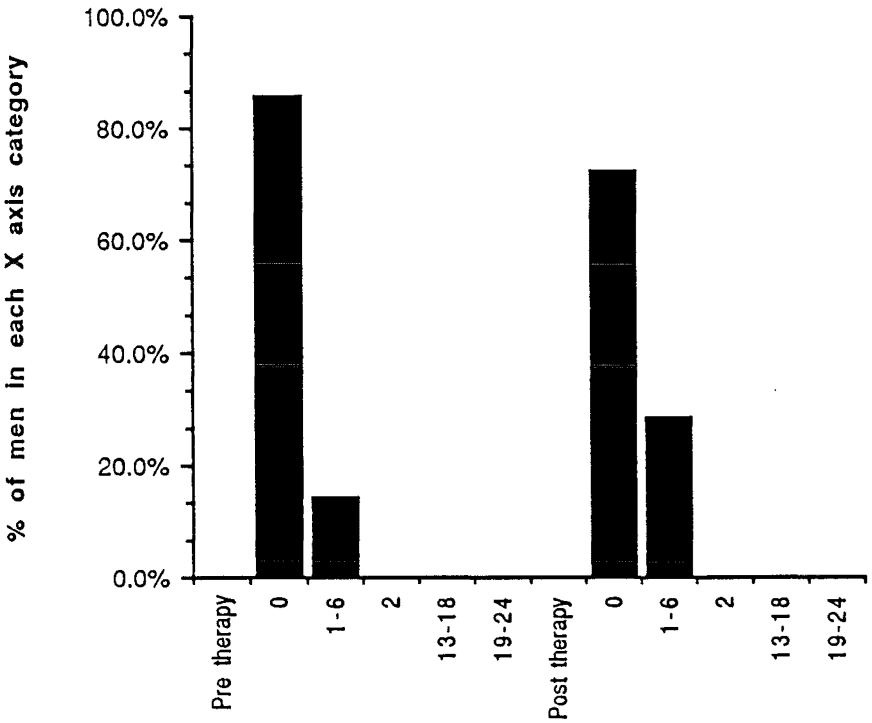



Number of times FEAR mentioned in 24 responses

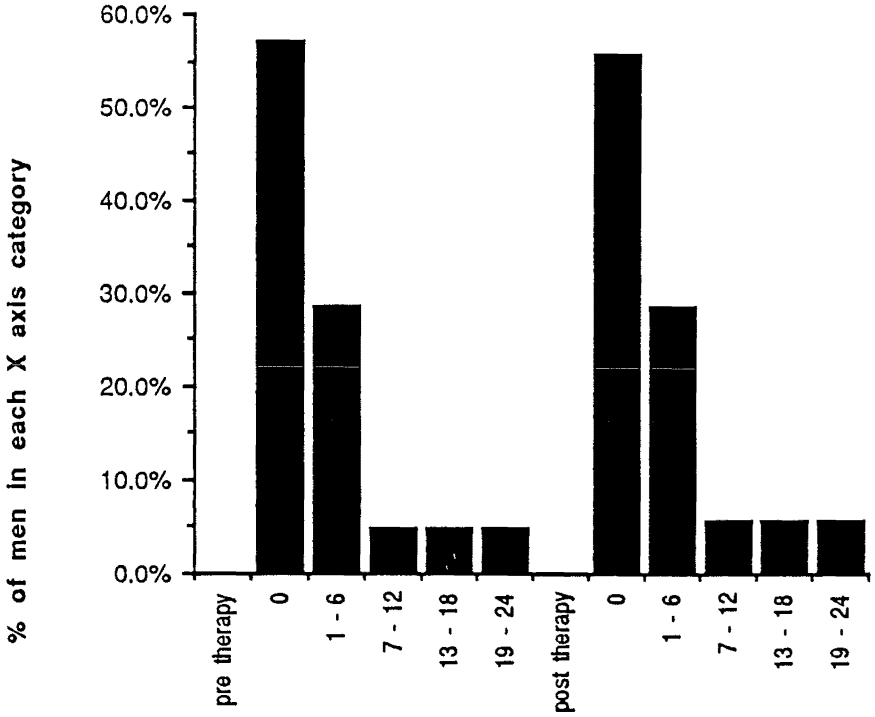
## Appendix M. cont.



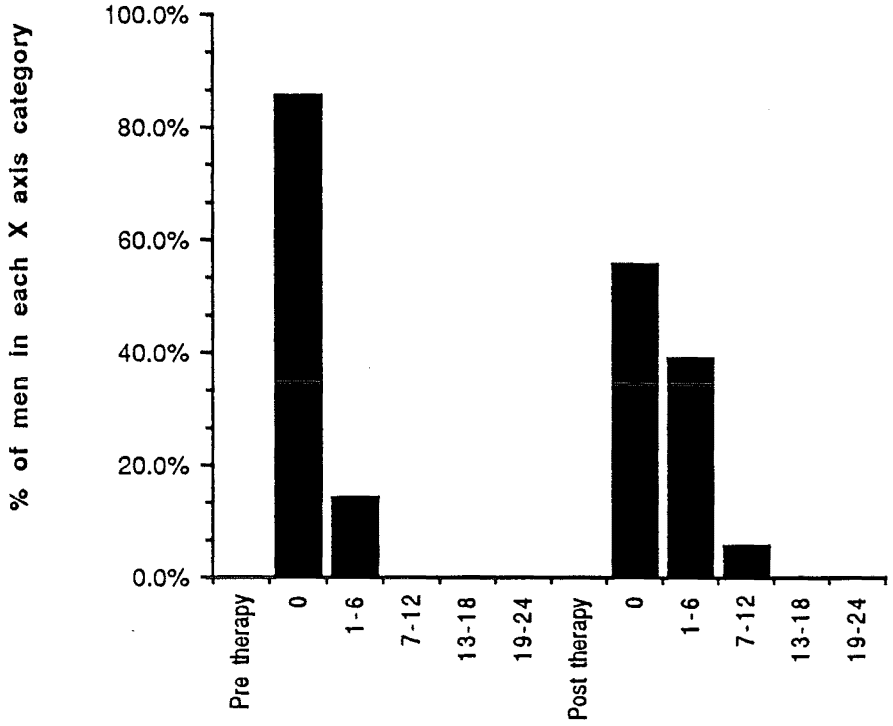

Number of times GOOD mentioned in 24 responses




Number of times GOOD DURING, BUT BAD AFTER mentioned in 24 responses

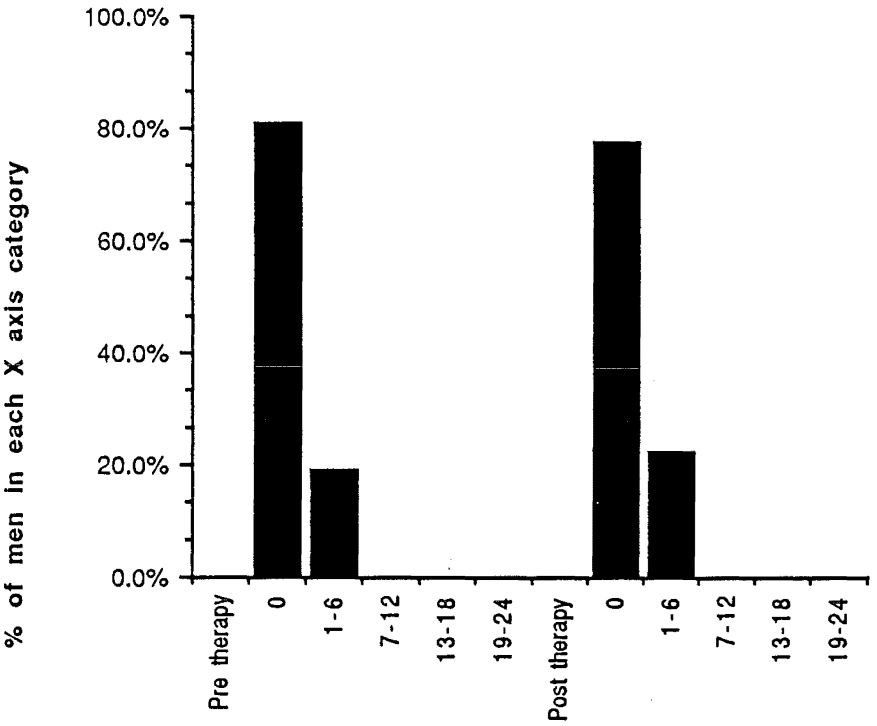



Number of times AROUSAL mentioned in 24 responses

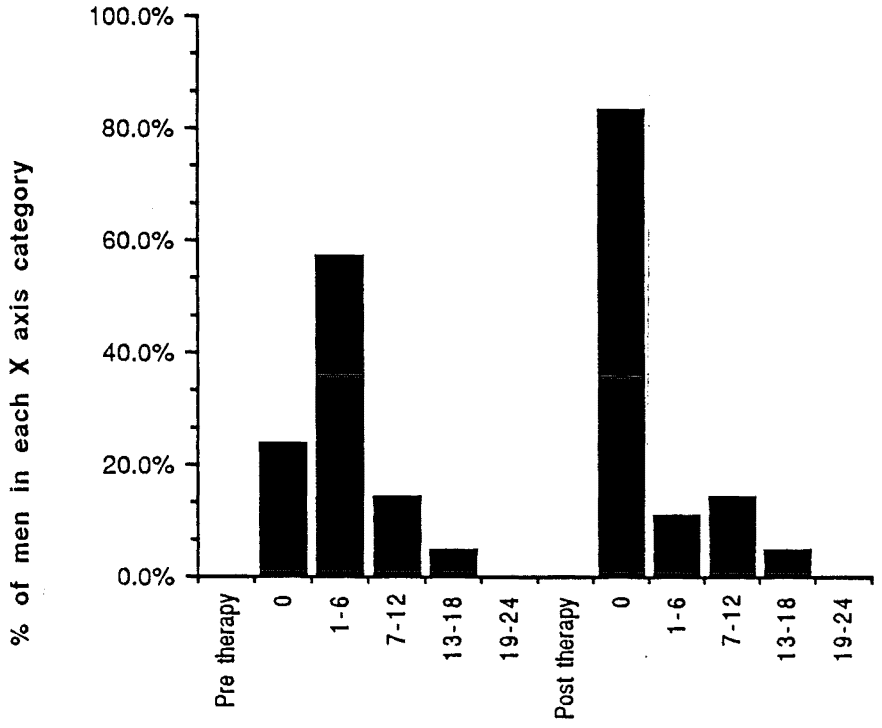



Number of times GOOD AND BAD feelings mentioned in 24 responses

## Appendix M. cont.

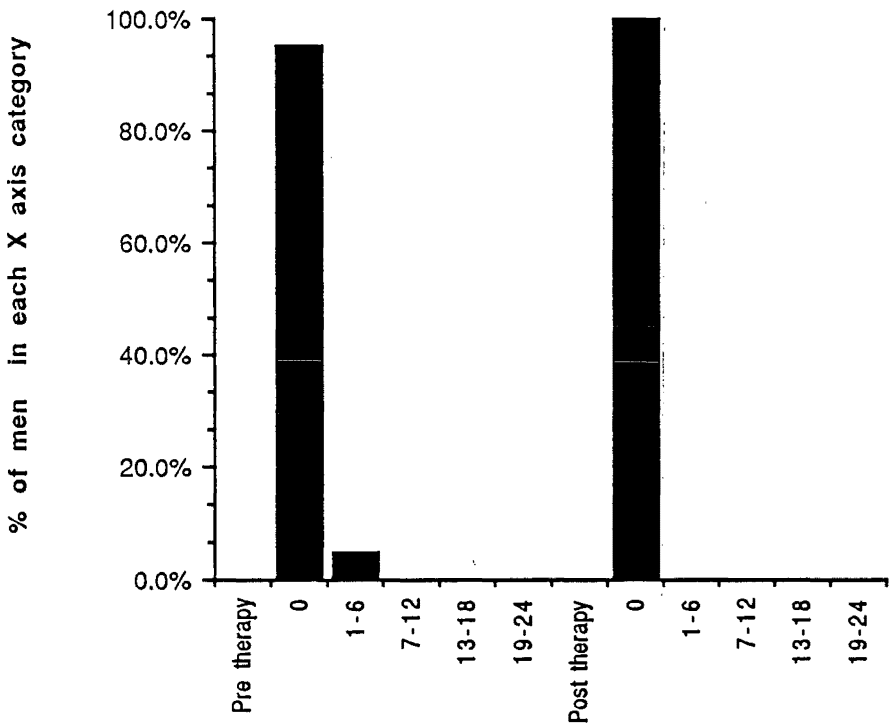



**Number of times CAN'T STOP mentioned in 24 responses**

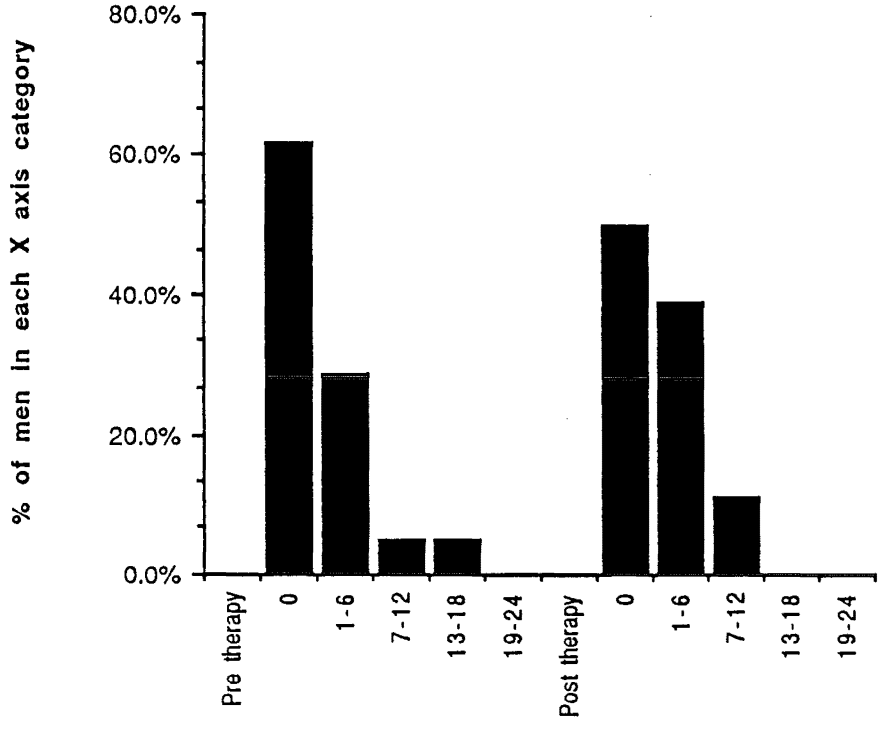



**Number of times "WOULDN't DO IT"was stated in 24 responses**

## Appendix M. cont.

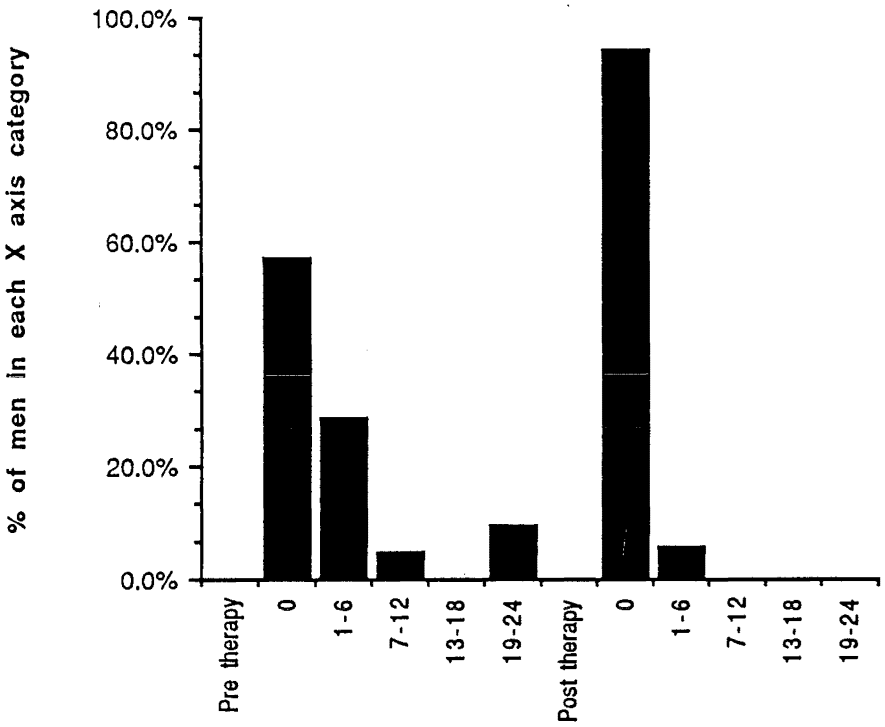



Number of times scenario said to be O.K. in 24 responses

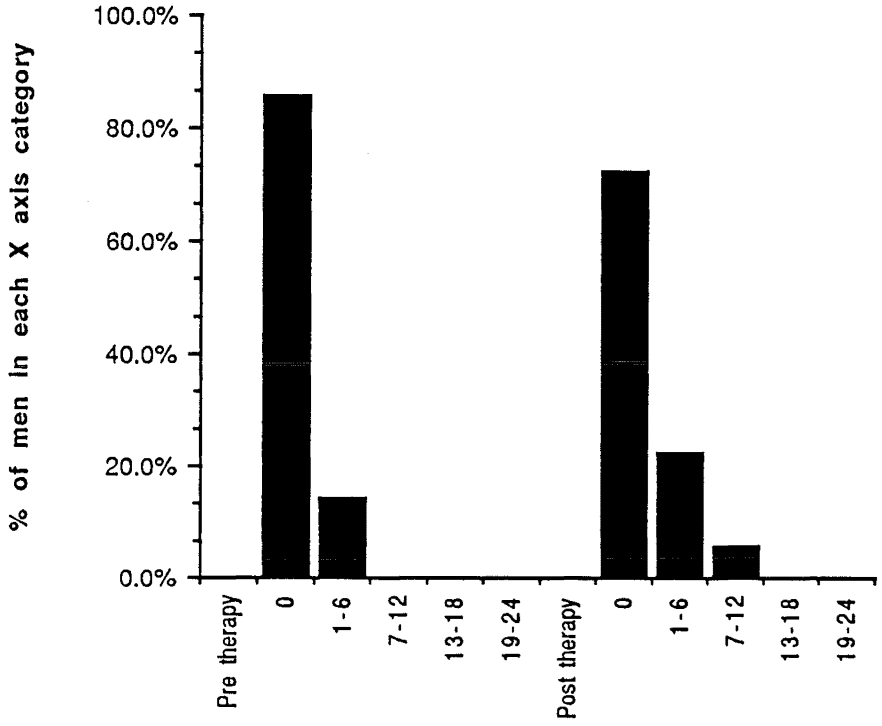



Number of times scenario said to be NOT O.K. in 24 responses

## Appendix M. cont.




Number of times DONT KNOW mentioned in 24 responses




Number of NEUTRAL answers in 24 responses

## Appendix N.

## Offender Responses not falling in main categories.

Because of the free response nature of this questionaire, some of the information gathered can not be adequately accounted for in a finite number of categories.

Responses that give significant clues as to the thoughts feelings and motivations of inmates ,but that don't fit into the categories outlined previously are included in the following section.

Scenarios are described in order of gender, age and level of sexual interaction, with both pre and post therapy offender responses ( not previously recorded) following each scenario.

**Female victim, < 6 yrs , fondling :**

"Sarah is about 4 years old. She is at home with you while her parents are away. She hears a noise in her room and gets scared, so runs to you for comfort. While she is sitting on your lap, you begin to rub your hands all over her body, including between her legs. She sits there, not moving."

PRE THERAPY COMMENTS

- dirty
- really low
- bloody horrible
- let her down because I've not protected her
- disgusted
- I would wonder what was happening to me and why I started touching her
- aroused, nervous, shaking, sick, mixed up-sexually and emotionally
- like killing myself
- can't relate to this as the perpetrator; as the reader I feel disgust, shame, pity, anger, sadness, revenge, revulsion, understanding
- stupid to try something on someone with no sexual feelings yet

-probably aroused but no sustainable erection
- sick and depressed
- like a heel
- like a sick dog inside my guts -OK
- utterly ashamed of myself;feel sick just thinking about it

POST THERAPY:
- upset
- low ( *2 )
- angry ( *2 )
- disgusted ( *4 )
- dirty
- sick
- hate myself ( *2 )

**Female, < 6yrs , masturbation:**

"Jenny is about 3. She is sitting on your lap and jiggling around a lot. You find yourself getting aroused, and you start to masturbate against her. You rub your penis against her till you have an orgasm."

PRE THERAPY:
-shouldn't be doing this
- shocking, terrible
- very disgusted with myself
- disgusted
- not very proud of myself for doing it to her
- can't relate to this as the perpetrator; as the reader I feel disgust, shame, pity, anger, sadness, revenge, revulsion, understanding
- children don't feel sexual usually; probably done to relieve creeping nothing feeling
- sick
- nothing
- excitement and satisfaction after orgasm

POST THERAPY:

- upset
- angry
- low
- breach of trust
- sexually released
- sick ( *4 )
- anger for what I did
- confused
- disgust ( *4)
- didn't do harm, too young
- annoyed with self

**Female, < 6yrs, penetration:**

"Susan is about 5. When her mother is out working at night, you go in to check her. Sometimes you climb in and feel her, sticking a finger in her vagina. She pretends to be asleep."

PRE THERAPY:

- bloody horrible, I've been the cause of it
- very very disgusted
- disgusted
- I would feel very sad for doing it and try and find help
- aroused, mixed up, shaky, sick, scared
- like killing myself
- apart from not doing it myself under the blanket -no problems
- can't relate to this as the perpetrator; as the reader I feel disgust, shame, pity, anger, sadness, revenge, revulsion, understanding
- sick ( *2)
- I don't do this at all ; not at that AGE ANYWAY. I feel bloody sick about it happening ok
- excited by the danger of being caught

POST THERAPY :

- disgusted ( *4 )
- excited
- sick (* 5 )

- warm
- enjoying
- pity
- confused- why am I doing this
- low esteem
- unclean
- lonely
- frightened
- mad, angry
- betraying trust
- have my needs met
- not happy but can't stop
- guilty
- ashamed
- dirty

**Female <6 years, force:**

"Lucy is about 5. You are looking after her while her parents are away. After her bath you carry her to bed and feel her body with your hands. You lower your trousers and lie against her. She tells you to stop but you keep going just long enough to have an orgasm."

PRE THERAPY:
- shouldn't be done
- horrible-I wouldn't do it
- disgusted with myself
- disgusted
- very unhappy for doing such a thing to her
- she has said to stop so I would and say sorry, kiss her, and say it was wrong what I did and not do it again in fear of being told on.
- can't relate to this as the perpetrator; as the reader I feel disgust, shame, pity, anger, sadness, revenge, revulsion, understanding
- difficult to maintain an erection, with wanking could stay hard.some fear of mess to clean up and fear of blood on clothing

- sick
- don't know, she's too young
- excited by danger of discovery

POST THERAPY:

- horrible
- sick
- guilt
- sick (*4)
- confused
- unclean
- disgust (*5)
- confused
- repulsion
- dirty

**Female 7-11 , fondling:**

"Megan is about 7. You help put her to bed when her parents are out. While you are taking off her clothes you fondle her, particularly around her nipples and between her legs. She doesn't say anything."

PRE THERAPY:

- shouldn't be done
- horrible, wouldn't be able to face her the next day-so guilty it would play on my conscience
- very disgusted with myself
- disgusted
- you shouldn't be doing such a thing and try to find help
- like killing myself
- can't relate to this as the perpetrator; as the reader I feel disgust, shame, pity, anger, sadness, revenge, revulsion, understanding
- dangerous when says I love you and my name is so close. Can I relax? It's something I don't usually do, so PESTER can't keep away unless I leave site
- sick

- angry depressed guilty
- a real dip shit
- excited but afterwards scared that she might tell her parents

POST THERAPY:

- disgusted (*4)
- sad
- angry(*2)
- confused
- breach of trust
- nice body
- angry and sad
- I'm playing Doctor
- sick
- disappointed
- dishonest
- ugly

**Female 7-11, oral sex:**

" Melanie is about 10. You sometimes come into her room at night, pull up her nighty, and give her oral sex. She acts as though she's asleep."

PRE THERAPY:

- shouldn't happen
- bloody horrible
- feel like a coward to do it
- disgusted (*2)
- wish you could stop what you are doing to this child and feel very g----and stop until next time
- aroused, confused scared sick, mixed up,hoping she'd say nothing to any body
- can't relate to this as the perpetrator; as the reader I feel disgust, shame, pity, anger, sadness, revenge, revulsion, understanding
- probable pleasure as this is not a messy situation

- sick and depressed
- depressed and wondering why I would go this way
- sick in the fucking head and gut about it
- at the time satisfaction and power, now utter disgust

POST THERAPY:

- low
- sexually frustrated
- very bad
- disgusted(*5)
- like the whole world has come down around me
- madness
- hate myself(*2)
- angry(*2)
- scared
- sick(*2)
- worthless

**Females 7-11, penetration:**

"Anna is about 10. You sometimes have intercourse with her at night when there's no-one around. She usually keeps very quiet and still."

PRE THERAPY:
- terrible
- horrible(*2)
- disgusted
- very nervous and wish you could tell someone you are doing it to Anna, but don't know who to tell.
- aroused but knowing I'm doing wrong, feeling sick and shaky inside; feeling what she must be feeling; scared, sick, very mixed up sexually and emotionally
- like killing myself
- can't relate to this as the perpetrator; as the reader I feel disgust, shame, pity, anger, sadness, revenge, revulsion, understanding

- obviously if was having intercourse with her I wouldn't have any feelings
- curious, alone, intense need for change in emotion- has been static for days- try to reach a new emotional state by doing something new- relief at her quiet stillness
- down
- sick
- guilty , embarrassed, ashamed, depressed
- bloody horny, O.K.
- superior, power over her; showing her love, or love as I know it. I know its wrong, but the risk of being caught adds to the excitement

POST THERAPY:
- upset (*2)
- disgusted with myself (*6)
- degraded
- sick (*3)
- lonely
- bored
- no respect no purpose
- frustration
- angry (*2)
- where can I get help
- worthless
- hate self
- hurt
- dirty
- low

**Females 7-11, force:**

"Karen is about 11. One night you come into her room and fondle her. She yells and kicks but you put your hand over her mouth and hold her while running your hands over her breasts and exploring her body."

PRE THERAPY:
- terrible

- very disgusted
- disgusted(*2)
- very unhappy to find the only way of getting happiness from an 11 year old and try and find help.
- I would ask if they liked it and stop soon after. Would feel nervous, aroused, shaky
- scared as hell, I would not go so far if the girl kicked and yelled
- can't relate to this as the perpetrator; as the reader I feel disgust, shame, pity, anger, sadness, revenge, revulsion, understanding
- stupid to pick on lively girl, kick in groin is hard to take, possible revenge motive to kick in
- sick
- scared shitless
- frightened

POST THERAPY:
- upset
- terrible
- angry
- warmth
- take off or stay? and worry after
- anger for what I did (*2)
- low esteem
- respect nothing, to hell with you
- hate myself
- exciting expression of control
- disgusted (*3)
- sick
- bully, rapist and pretty low

**Female > 12, fondling:**

"Sally is about 13. You sometimes come into the bathroom while she's undressed and run your hands over her body, including her breasts and between her legs. Sometimes she giggles and turns away."

PRE THERAPY:
- bad
- bloody horrible
- shocking; guilty; you know your doing wrong
- disgusted (*2)
- I would say that I was missing something in your (my) life and would feel unhappy after doing that to Sally
- aroused, scared sick, physically mixed up
- like killing myself
- can't relate to this as the perpetrator; as the reader I feel disgust, shame, pity, anger, sadness, revenge, revulsion, understanding
- excitement, stimulation, great need for sexual pleasure,and a wank would probably be enough after, or worse thoughts will trouble me
- sick and depressed
- ashamed after- during, I'd be feeling good/sexual
- a real fuck head
- excited at first, then scared as the situation escalated beyond our control

POST THERAPY:
- upset
- disgusted (*5)
- sick (*3)
- angry
- worthless
- hate self

**Female >12, masturbation:**

" Monique is about 13. You babysit for her. When she's in bed, you some-times go to try and arouse her, by running your hands over her body and masturbating her between her legs. She moves about quite a bit."

PRE THERAPY:
- wouldn't want to do this

- terrible, the guilt would come out- you wouldn't get rid of it out of your mind
- very disgusted with myself
- disgusted (*2)
- not very proud and wonder if its mucking up her life
- aroused, scared, mixed up,sick, shaky
- like killing myself
- can't relate to this as the perpetrator; as the reader I feel disgust, shame, pity, anger, sadness, revenge, revulsion, understanding
- glad she doesn't suck or run away- that will probably happen
- sick
- excited, embarrassed, guilty, depressed.
- a real fuck head and real sicko
- power, sexual satisfaction, and a trifle scared that full intercourse could have occurred.

POST THERAPY:
- low, disturbed
- confused (*2)
- sick (*2)
- dirty, unclean
- respond recognition
- hear my cry
- lonely, need
- betraying trust, low esteem
- angry
- disgusted
- worthless; rat
- low down, hate myself
- encouraged at interest
- not worth it

**Females >12, penetration**

"Amanda is about 14. You sometimes go into her room when she is sleeping. One night you gently climb into her bed and end up having intercourse with her. She doesn't say anything and lies fairly still."

PRE THERAPY:

- shouldn't be done, plus make my life harder
- horrible
- terrible
- very disgusted with myself
- disgusted (*2)
- very unhappy and hope you can find help
- aroused, mixed up, nervous, shaky
- like killing myself
- can't relate to this as the perpetrator; as the reader I feel disgust, shame, pity, anger, sadness, revenge, revulsion, understanding
- I've done things she'd get in a few weeks time anyway
- fearful as this person gains her adult rights- hope to keep this mum
- sick and depressed
- really disgusted in what I have done to here
- I feel sick with this situation as it could have happened to be and I feel frightened that I was capable of doing such a thing

POST THERAPY:

- disgusted (*2)
- anger (*2)
- confusion
- low esteem
- disgust(*3)
- lonely
- sorrow
- no place for me
- self pity
- stress
- belonging
- a heel
- this is rape
- gotta get pleasure when you can
- sick
- ugly

- no good
- low down

**Females >12, force:**

"Joanne is about 15. One night she is getting ready for bed when you come in and put your arms around her. She struggles, but you are too strong. You throw her on the bed and have intercourse with her."

PRE THERAPY:
- horrible (*2)
- disgusted with myself as she's under age
- I don't force anyone to do anything
- disgusted
- I would feel excitement at the moment, but then after it had been done, I'd think what will she think of me after the intercourse
- I would never hope to be in this situation
- pretty stink because I'm not a violent person
- joy at expression of my skill,fear of fact she won't keep quiet. Must clean up any mess
- sick, terrible
- I feel as she does(i.e. sick,angry, embarrassed and guilty) but also depressed that I could do such a thing
- I feel bloody dirty as she does

POST THERAPY:
- upset
- angry
- rotter
- disgusted (*5)
- sick (*3)
- guilty
- rotten
- angry
- hurt
- worthless
- hate self

**Males <6, fondling:**

"Robert is about 2. He is running around with no clothes on, ready for his bath. You catch him and start fondling his body, including his genitals. He energetically wriggles around."

PRE THERAPY:
- wouldn't do it
- horrible- a kid that age
- very disgusted
- disgusted (*2)
- I wouldn't do this
- like killing myself
- can't relate to this as the perpetrator; as the reader I feel disgust, shame, pity, anger, sadness, revenge, revulsion, understanding
- good smooth body to touch
- not much stimulus- minimal excitement if any
- sick
- nothing
- sickened

POST THERAPY:
- dirty
- disgusted (*3)
- sick (*2)
- not belonging
- dirty (*2)
- disgusted (*2)
- hurt ugly
- low down

**Males >6, masturbation/oral sex**

"Gareth is about 4. You sometimes sit him on the couch, pull back his shorts, and lick his penis. He doesn't usually say much."

PRE THERAPY:

- sick inside
- yuk
- bloody horrible
- like an animal, sordid, disgusted, depraved sort of mind
- disgusted (*2)
- what he is thinking about what I'm doing to him and what he thinks of me and not the right thing to do
- frightened, bewildered, about what was happening to me
- can't relate to this as the perpetrator; as the reader I feel disgust, shame, pity, anger, sadness, revenge, revulsion, understanding
- good since Gareth says nothing- smooth body to touch
- nothing - can't identify experience
- sick and disgusted with my self
- nothing
- fuckin sick
- sick that I've stooped so low and done what I've done to my step children and stuffed up a perfectly good marriage

POST THERAPY:

- disgusted (*5)
- repugnant
- mad why am I doing this
- degraded
- sad
- guilty
- sick
- angry
- hurt
- disgusted
- worthless
- scared
- hate self

**Males <6 penetration:**

"Andrew is about 4. You are watching T.V. with him while his parents are out. He is snuggling upon the couch with you and is pressing against your penis. You enjoy the sensation of his body next to yours, and find yourself tempted to be naked with him. You quietly loosen your clothes and his and have sex with him. He asks what you're doing but doesn't try to get away."

PRE THERAPY:
- horrible, terrible
- very disgusted with myself.
- disgusted (*2)
- can't relate to this as the perpetrator; as the reader I feel disgust, shame, pity, anger, sadness, revenge, revulsion, understanding
- comfortable and relaxed
- annoyed that I have to wash him
- nothing
- I would enjoy the sensation of his body but stop at sex, for sex with boys disgusts me

POST THERAPY:
- excited
- rotten
- ugly
- anger (*3)
- pity
- sick (*3)
- confused
- dirty (*2)
- mad
- disgusted (*4)
- didn't like it happening to me when I was young
- repulsion

**Males <6 force**

"David is about 5. After you've got him out of the bath you start licking his penis. He struggles and tells you to stop, but you hold him still. You enjoy the feel of his skin."

PRE THERAPY:
- shouldn't be done
- bloody horrible
- very dirty
- ashamed as the child did not want it
- disgusted
- when told to stop I would
- never done this
- like killing myself
- can't relate to this as the perpetrator; as the reader I feel disgust, shame, pity, anger, sadness, revenge, revulsion, understanding
- comfortable and relaxed
- if I started I might wish not to stop
- sick and depressed
- nothing
- nothing at first, then scared because I've lost control of a situation that should never have happened

POST THERAPY:
- dirty
- angry at self
- disappointed
- disgusted (*4)
- sick(*5)
- confused
- why did I do it
- anger, I didn't like it done to me, so why do I do it
- excited
- in control
- not happy, don't want to do it
- dirty
- hate self
- bloody awful

**Males 7-11, fondling:**

"Stephen is about 8. Sometimes when he is having a bath, you go in and rub your hands all over his body, including his genitals. He wriggles around a lot.

PRE THERAPY:
- dirty
- horrible (*2)
- disgusted
- very nervous and wish you could tell someone about what you are doing to this child
- not sure- depends on how he feels
- never done it so can't answer
- good and happy
- nothing much as it's not a personal stimulus for me
- terrible
- annoyed that I have to wash him
- betrayed, misunderstood, dirty soiled property, and no good to anyone at all, O.K.?
- at last he is being made to do or have this abusive behaviour inflicted on him whether he likes it or not

POST THERAPY:
- disgusted (*5)
- stupid
- sick
- no good
- low
- dirty
- hurt
- hate self

**Males 7-11 , masturbation**

"Matthew is about 8. He often climbs into your bed in the mornings. One morning, you start feeling him and then masturbate against him. He lies quite still."

PRE THERAPY:

- bloody shocking
- bad about yourself
- disgusted
- wondering why you'd do such a thing to a young boy
- damn it, I've never done this to a boy
- like killing myself
- can't relate to this as the perpetrator; as the reader I feel disgust, shame, pity, anger, sadness, revenge, revulsion, understanding
- comfortable and relaxed
- glad he's so cooperative
- secretly hope I can teach the boy some pleasure so it's mutual
- sick and depressed
- nothing
- confused, knowing it's wrong but feeling like a falling domino unable to control the situation

POST THERAPY:

- low, dirty
- disgusted (*6)
- sick (*2)
- unclean
- repugnant
- pity
- angry with myself
- sad
- lousy
- worthless
- low
- hate self
- angry

**Males 7-11 penetration:**

"John is about 11. You take him tramping. During the night, you remember watching him undress. You move closer to him and feel the smoothness of his back and buttocks. You have anal intercourse with him. He pretends to be asleep."

PRE THERAPY:
- I feel terrible about myself
- a real heel,a terrible man
- disgusted (*2)
- I had betrayed his trust and being alone with him out on your tramp with him and hope it wouldn't happen again
- haven't done this but probably would feel aroused, sick physically, shaky, scared, confused sexually and emotionally
- can't relate to this as the perpetrator; as the reader I feel disgust, shame, pity, anger, sadness, revenge, revulsion, understanding
- comfortable and relaxed
- wouldn't dare do it to a boy, cos I'm a boy myself. But brief relief of the creeping nothing feeling
- depressed and sick
- nothing
- unsure and unsafe and sickened that it happened
- never done this and feel very uncomfortable having to answer this question

POST THERAPY:
- upset (*2)
- terrible, violating trust
- betraying trust
- sorry
- sick (*3)
- confused
- disgust (*5)
- alienation
- hate myself (*2)
- angry (*2)
- worthless

- low

**Males 7-11, force:**

"William is about 10. One afternoon, when he is alone in the bathroom after having a shower, you go in and start to feel his back and buttocks. He tries to wriggle free but you hold him, enjoying the feel of his silky smooth skin."

PRE THERAPY:
- horrible, I wouldn't do it
- very disgusted
- disgusted (*2)
- very unhappy about doing such a thing to a 10 year old boy
- aroused, nervous, shaky, mixed up, but would stop because of his struggling
- can't relate to this as the perpetrator; as the reader I feel disgust, shame, pity, anger, sadness, revenge, revulsion, understanding
- like killing myself
- not satisfied with William's reactions
- apart from not doing it under the blanket, no problems
- sick
- nothing
- excited by the feel of his skin
- confused and frightened about being caught

POST THERAPY:
- bitter
- a jerk
- a bloody shit house
- disgusted (*3)
- sick (*3)
- good but confused
- disgust
- self disgust
- sad, angry
- power over him
- it wasn't really that bad

- feeling sick and nervous
- angry
- dirty, hurt

**Males > 12 fondling:**

"Henry is 12. When he is away on camp with you, you fondle him. Sometimes you put your hands down Henry"s pants and play with his genitals, till he gets an erection."

PRE THERAPY:
- know I shouldn't be doing it
- horrible
- very disgusted with myself
- disgusted (*2)
- I've never done this but would probably feel aroused, nervous, shaky, mixed up
- can't relate to this as the perpetrator; as the reader I feel disgust, shame, pity, anger, sadness, revenge, revulsion, understanding
- comfortable and relaxed
- I don't do this, but more excited than minimal because of risk of comment
- sick
- nothing
- excitement, sense of power and satisfaction in outcome

POST THERAPY:
- upset
- uneasy
- sick (*2)
- confused
- low esteem
- control
- disgusted (*2)

**Males > 12, masturbation / oral sex:**

"Michael is about 13. One night you go into his room and sit next to him on the bed. You put your hand in his pyjama pants, feeling his penis, then you take it in your mouth, sucking till he gets an erection."

PRE THERAPY:
- I'd never do it, bloody horrible, the thought of it turns me off
- very disgusted
- disgusted (*2)
- never done this
- like killing myself
- can't relate to this as the perpetrator; as the reader I feel disgust, shame, pity, anger, sadness, revenge, revulsion, understanding
- comfortable and relaxed
- a little sick as this is the first time I've tried to suck. Hope all pleasure is mutual- if not break away
- sick and depraved
- nothing
- a sense of power, but also discomfort for engineering the situation and afterwards a sense of inadequacy

POST THERAPY:
- upset
- sick (*2)
- sorry
- unclean
- anger for doing it (*2)
- confused
- self hate, dirty (*2)
- low down
- shame
- mad, angry
- awful
- one's gotta get pleasure out of life
- depraved
- miserable
- disgusted (*2)

**Males > 12, penetration:**

"Jim is about 13. You go in to check up on him, and find yourself becoming very aroused by the thought of touching him. you end up climbing into his bed, and having anal intercourse with him. He asks what you are doing but doesn't yell or try to get away."

PRE THERAPY
- shouldn't do it
- terrible
- very disgusted with myself
- disgusted (*2)
- sick!! I've never had sex with a male boy
- can't relate to this as the perpetrator; as the reader I feel disgust, shame, pity, anger, sadness, revenge, revulsion, understanding
- comfortable and relaxed
- sick
- nothing
- anal sex is a digusting practice to me - sickened

POST THERAPY:
- degraded
- sorry for him
- encouraged
- sick (*4)
- confused
- disgust (*7)
- foul
- beyond words
- repulsion
- hurt
- dirty
- annoyed with self

**Males > 12, Force:**

"Richard is about 14. He often plays with you. One day when you're having a wrestle, you feel yourself getting an erection. You find yourself wanting to look at and touch Richard's penis. You try to lower his shorts, but he holds on to them and says "don't." You hold his hands behind his back and take down his shorts with your free hand. you masturbate him till he gets an erection."

PRE THERAPY
- horrible, it's a thing you wouldn't do
- disgusted with myself
- disgusted (*2)
- that I should hold my affections back and not take them out on a 14 year old boy and hope he would tell someone to help me
- when told to stop I did
- can't relate to this as the perpetrator; as the reader I feel disgust, shame, pity, anger, sadness, revenge, revulsion, understanding
- not satisfied with Richard's reactions
- clever, cunning, a little disappointed and angry at having to hold his hands behind his back. This is coercion only, not really cruel
- sick and depressed
- nothing
- a real sicko for doing it in the first place
- utter disgust that I've done this

POST THERAPY:
- mad at myself (*4)
- cowardly
- hurt (*2)
- breach of trust
- angry (*2)
- disgusted (*4)
- sick
- worthless